

UNITED STATES DEPARTMENT OF AGRICULTURE

IN RE:)
)
DIETARY GUIDELINES)
ADVISORY COMMITTEE MEETING)

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THE UNITED STATES DEPARTMENT OF AGRICULTURE

In the Matter of:)
DIETARY GUIDELINES ADVISORY)
COMMITTEE MEETING)

Wednesday,
March 10, 1999

Waugh Auditorium
1800 M Street, Northwest

Washington, D.C.

The proceeding in the above-entitled matter was reconvened, pursuant to Notice, at 9:06 a.m.

BEFORE: Cutberto Garza,
Chairman

P R O C E E D I N G S

(9:06 a.m.)

1
2
3 CHAIRMAN GARZA: We want to congratulate all the
4 committee members on getting in here. With no cabs, that's
5 a real testament to everyone's commitment, to say nothing of
6 all of you who have come to join the committee. That's a
7 real testament of your commitment as well, although I
8 understand from Shanthy that the roads in Washington, D.C.
9 are deserted. Another way one can stop government. Two
10 inches of snow. Unfortunately, it serves to reconfirm the
11 prejudices that many of us have about government.

12 All right, we're going to try and work today
13 through lunch again because there are several that would
14 like to be able to make 2:00, or get to the airport around
15 2:00, so that if we can do this officially, we'll try to do
16 it. Probably make a decision somewhere around 10, so we
17 don't get quite a frantic about trying to get lunch brought
18 in and perhaps we could arrange for our conference room to
19 have lunch quickly, so that we are not always in the same
20 room throughout the whole period. People got cabin fever
21 yesterday, I think, with a marathon. But that's the general
22 schedule.

23 What I'd like to be able to accomplish before
24 getting to the working group reports is have a general
25 discussion for about 15 - 20 minutes, leading with how you
26 feel based on the exchanges we had in the last two days, we
27 ought to be configuring the guidelines, regardless of the
28 number we come up with, whether you feel there are major
29 changes to the general configuration. We've had several

1 groups that testified on Monday suggests that in fact we
2 ought to consider some type of tier system to make it easier
3 for consumers to be able to assimilate the information that
4 we give them.

5 Others, however, I think the American Dietetic
6 Association in particular, testified that in fact they
7 feel that all the guidelines should be given equivalent
8 weight, and that a tier system, if I'm remembering comments
9 correctly, is not something that they would recommend or
10 that organization would recommend.

11 We talked -- the various working groups discussed
12 other alternatives, somewhat perhaps with tongue in cheek,
13 should we separate do's from the don'ts, and how some sort
14 of balanced approach, a balanced picture that says this is
15 what you're supposed to do, this is what you're not supposed
16 to do as a way of organizing them in a system that would
17 make them easier to assimilate.

18 So let's begin there because I think it may help
19 then with the remainder of the discussions, and I don't
20 think we need to necessarily come up with a way, but if we
21 can narrow it down to two or three, certainly no more than
22 three, approaches, then as we begin writing and Carol Suitor
23 begins to put this information together, then she can
24 take -- we can prioritized them, begin to look at some
25 alternate ways of piecing the various working group outputs
26 in a way that is consistent with that prioritization that we
27 come up with.

28 So are there -- is there any comments about
29 keeping them the way they are, some sort of tier group?

1 One suggestion, for example, in keeping -- in the
2 tier group is that we ought to put -- I forget who suggested
3 this to me -- salt, sugar, alcohol, and there is a fourth
4 one. Sugar, salt, alcohol.

5 DR. JOHNSON: Weight.

6 CHAIRMAN GARZA: No, it wasn't the weight one.
7 Sodium, in a second.

8 VOICES: Sodium is salt.

9 (Laughter.)

10 CHAIRMAN GARZA: I thought there were four. Well,
11 maybe there are three. Anyway, put those three in a -- no,
12 no, fat people wanted -- is the people that I spoke with,
13 thought that it would be best to try to put it in the top
14 tier because you could integrate it much more easily with a
15 high fruit, vegetable, grain diet. But that was one
16 approach that was discussed.

17 DR. JOHNSON: I also like the idea of having the
18 concept of adequacy, variety or whatever we settle on, and
19 safety as sort of the over-arching theme. You know, that
20 your diet has to be adequate and safe is sort of the first
21 priority, and then we had talked about that.

22 CHAIRMAN GARZA: So something along the lines that
23 Suzanne presented, Rachel. In her initial presentation, she
24 had a pyramid, for example, linking the other six
25 guidelines, having two icons linking the other whatever
26 number we come up with --

27 DR. JOHNSON: Um-hmm.

28 CHAIRMAN GARZA: -- safety and adequacy, then
29 bringing it all together? Okay.

1 Johanna and them Meir.

2 DR. DWYER: I think that the adequacy goes well
3 with something in the text about food security, but that the
4 two concepts are different and that they should be separated
5 into separate guidelines.

6 CHAIRMAN GARZA: Adequacy?

7 DR. DWYER: Adequacy.

8 CHAIRMAN GARZA: Food security? Are you
9 suggesting then another guideline on food security?

10 DR. DWYER: No, I'm suggesting one on adequacy
11 that mentions food security.

12 CHAIRMAN GARZA: Food security, okay.

13 DR. DWYER: And then another one that's on food
14 safety --

15 CHAIRMAN GARZA: Yeah.

16 DR. DWYER: -- because they are separate concepts.

17 CHAIRMAN GARZA: No, I didn't know whether you
18 meant security, adequacy and safety. That's why I wanted to
19 clarify that.

20 Meir.

21 DR. STAMPFER: I think that tier, if we call it
22 that, tiered approach is a good one or somehow some kind of
23 grouping because clearly the health effects of these
24 guidelines differ, and, in particular, the sodium guideline
25 is pretty much geared toward more on risk factor, blood
26 pressure. The sugar guidelines is geared mainly as the
27 displacement of nutrient, other nutrients issue. And the
28 alcohol guideline is more just information rather than
29 recommendation of any sort, except the recommendation not to

1 drink for those who fit into that category. So I think
2 those could be grouped as a secondary kind of other, and
3 maybe not even have their own headlines.

4 CHAIRMAN GARZA: You know, that's interesting
5 because we're moving now to a more of a Meso-American
6 pyramid than an Egyptian one. I think they were tiered in
7 Meso-America rather than straight.

8 DR. WEINSIER: John, I want to endorse the concept
9 of the tiered approach because I think that the guidelines
10 are all important, but not initially equally important. I
11 think we've identified several guidelines, the ones that
12 relate to plenty of grains, plenty of fruits and vegetables,
13 in the context of a reduced saturated fat, cholesterol
14 intake, and diets appropriate for weight control as more
15 important, highly important, and then we've got other
16 guidelines, as Meir is pointing out, that are still, you
17 know, worthy of note but without giving some feeling to the
18 person who's glancing at this, you know, what do I need to
19 look at, what do I need to take from here. If I forget
20 something, I don't want to forget this. So I like the
21 tiered approach.

22 CHAIRMAN GARZA: Okay, I'm getting a consensus
23 that you'd like Carol, as she begins to put this together,
24 to see how we could work with that tier approach, and we
25 will then be able to look at the outcome of that when we
26 meet again in June.

27 Is that -- so we're not asking you to make a final
28 decision, but at least as a first priority in organizing the
29 information we'll try to do it along these lines. And as

1 she interacts with the various working groups, then we may
2 have various guidelines moving in that tier, among tiers,
3 but that, I think, we can -- we can withstand that sort of
4 wobble for the moment as feedback comes in.

5 All right, then, let's move on then to the second
6 item before we get into the working group reports, and that
7 is having a sense from each of you when you are definitely
8 going to be unavailable between now and June because Carol
9 will be beginning to write from the information that you've
10 presented her, and begin to put pen to paper, identifying
11 those parts of our report where the information we've
12 supplied is sufficient and one can work those headings out
13 pretty well, identifying other places where there are
14 definite gaps, but begin to focus each of our attention,
15 obviously, on where those gaps are as quickly as possible,
16 and giving you something that you can react to as the final
17 author of this report.

18 Meir?

19 DR. STAMPFER: Can you be a little bit more
20 specific about how you see that process going? Are we
21 supposed to come up with something for Carol --

22 CHAIRMAN GARZA: No, no.

23 DR. STAMPFER: -- from the subgroups, or she
24 initiates it? What's the process?

25 CHAIRMAN GARZA: She will initiate it. For some
26 of the subgroups, we'll need more information. For example,
27 on the sodium one, it's definitely there that we need some
28 additional information to be able to get to that stage. On
29 the other hand, if we decide to go with a guideline on food

1 safety, there is enough information there that in fact all
2 Carol has to do is rearrange it in the format that the green
3 report presently is in, identify where there may be gaps,
4 get back to that group, or if she has questions in
5 organizing the information, getting that group to answer
6 those questions.

7 Perhaps, Carol, can you --

8 DR. SUITOR: I think that summarizes it quite
9 well. The food safety is probably the easiest one to start
10 with if it's decided that that's going to be one. And there
11 are others that are -- where your background information has
12 really laid things out pretty much the way you want them,
13 and I can work more efficiently if I initiate as opposed to
14 waiting for you to get me something additional, and I think
15 you'll be able to see better where you really want to change
16 things and I haven't been able to catch the idea you're
17 trying to get across and where you've been expressing
18 yourselves very clearly.

19 CHAIRMAN GARZA: Then we'll have the transcripts
20 of the meeting in about two weeks, and so Carol will be able
21 to refer to those transcripts of various presentations. And
22 if it's clear that issues came up which have not been dealt
23 with in the write-ups you've provided, then that gives her
24 then another source of being able to get back to you to
25 answer questions that remain unclear.

26 So with that in mind then, that you'll be sent
27 information that you'll be expected to respond to quickly,
28 and that's the operative word is quickly, because otherwise
29 we become such bottle necks in the process that it makes

1 Carol getting information back to us for the June meeting
2 impossible.

3 And so I'd like to ask each of you to send your
4 written schedule to Carol and Shanthy so that we'll know
5 those blocks of time where it's going to be impossible to
6 reach, assuming that the remainder of the time, given the
7 way we've structured this and having Carol do a lot of the
8 yeoman's work of putting this together for the group, that
9 in fact you'll be able to respond within 48 hours to
10 questions she might have, realizing that when you get a
11 draft to look at, you know, we may be able to go 96 hours,
12 is that fair, in getting back to you, you know, but not
13 three weeks because then it really -- it really makes the
14 process impossible because she will be trying to coordinate
15 comments that she will be getting first from the specific
16 working groups, but then also from perhaps more than one
17 working group if it's clear that there is some overlap
18 between information that she's dealing with.

19 DR. SUITOR: Or contradictions.

20 CHAIRMAN GARZA: Or contradictions, that's right.

21 DR. SUITOR: If people have their schedules with
22 them and want to tell us before you leave today.

23 CHAIRMAN GARZA: Well, that was the other thing --

24 DR. SUITOR: I've got a sheet.

25 CHAIRMAN GARZA: We're going to pass this sheet,
26 but I still would like -- you know, in addition to what you
27 tell us today, that's the compulsive part of my nature, when
28 you get back, you know, look at your schedules, compare what
29 you've told us, and get back to Carol so that we will have

1 at least two sources of information from you to extract
2 cooperation that you told us you were going to be -- Dr.
3 Stampfer is laughing.

4 All right, as each of you are looking at your
5 schedules, and assuming that you're multi-task individuals,
6 the third thing is that in discussions with the weight
7 maintenance group, and they'll be reporting a little later
8 today, there is some serious consideration begin given
9 within that group to asking the committee to consider
10 splitting the guideline on weight maintenance and physical
11 activity.

12 The rationale for that being, as I understand it,
13 is because physical activity is so much more important than
14 just weight maintenance, issues like being able to meet your
15 micro nutrient needs because you have a sufficiently high
16 calorie level is an important dietary issue. But then so
17 are issues that we're dealing with in terms of
18 cardiovascular disease and diet and physical activity, and
19 then physical activity and cancer, et cetera.

20 DR. DWYER: I was just going to say cancer --

21 CHAIRMAN GARZA: So there are a number of things
22 that speak to considering at least having that as a separate
23 guideline. If we do that, then we need to expand that
24 working group so that they can work on both guidelines since
25 we do expect for them to be some relationship between the
26 two and they can be a maximally compatible, if we decide to
27 go in that direction, at least this first go-around.

28 So before that group gets to make its report,
29 begin to think you feel we ought to be contacting as

1 consultants so that after the report you would have given us
2 some thought rather than asking everybody to respond with a
3 30 second or a minute warning.

4 Now, those are the three, so let's -- I don't know
5 whether there is any reason why we'd want to have a public
6 discussion of availability other than to try to work out
7 real conflicts of schedules. And if we can do it quickly,
8 it might be helpful just to see if there are blocks of time
9 when people will be unavailable for a two-week period; I
10 mean, where it's going to be impossible for us to get to you
11 because you either have a grant that's due, your secretary
12 is going to be on vacation, your significant other is
13 leaving you with all the kids. Having gone to that
14 experience, that is not trivial, a trivial happening. I
15 have great respect for single parents having gone through
16 that for only short periods of my life.

17 Okay, so why don't we begin with Richard. Any
18 periods that you're just not going to be around before our
19 June meeting, and the June dates are 14, 15, and 16.

20 VOICES: No, 16, 17 and 18.

21 CHAIRMAN GARZA: That's right.

22 MS. BOWMAN: Wednesday, Thursday, Friday.

23 CHAIRMAN GARZA: Wednesday, Thursday, Friday, the
24 16th, 17th and 18th. Okay.

25 Richard.

26 DR. DECKELBAUM: Do you want dates when I'll be
27 away one week or more?

28 CHAIRMAN GARZA: For one week or more?

29 DR. DECKELBAUM: March 23rd to April 9th, I'll be

1 in the Far East.

2 CHAIRMAN GARZA: Now, with the -- are others in
3 Richard's work groups going to be away the same time?

4 VOICE: Away meaning on e-mail?

5 CHAIRMAN GARZA: No e-mail, that's right. That's
6 the definition of "away" these days.

7 All right, so there is no real conflicts then with
8 working groups.

9 DR. DECKELBAUM: I'll definitely not be there.

10 CHAIRMAN GARZA: Exactly, but others in your
11 working group will be available, so that's good.

12 Okay, Rachel?

13 DR. JOHNSON: I'm always on e-mail.

14 CHAIRMAN GARZA: Wow.

15 DR. JOHNSON: While I'm away.

16 CHAIRMAN GARZA: All right, go ahead.

17 DR. JOHNSON: But not for large chunks.

18 CHAIRMAN GARZA: Roland?

19 DR. WEINSIER: Well, again with e-mail, it's not a
20 real concern. In terms of availability through April 8th,
21 with NIDD case section reviews, it's going to be very
22 difficult, and then we have the ASCN meeting and I have a
23 large part in the planning this year, and that's around also
24 April 17 through Tuesday the 20th. That's a major
25 constraint.

26 CHAIRMAN GARZA: Are there dates then from the
27 working groups that Roland is in, other members of those
28 working groups those dates are going to be a problem where
29 all of you are going to be unavailable?

1 Okay, good.

2 Shirika?

3 DR. KUMANYIKA: I don't see any major extended
4 periods when I'll be unavailable.

5 CHAIRMAN GARZA: Okay. Now, I should also say
6 that as we go through this I'm assuming that everyone has
7 agreed to sort of the response time that we've outlined.

8 Dr. Dwyer.

9 DR. DWYER: Yes.

10 CHAIRMAN GARZA: Okay, good.

11 DR. STAMPFER: Just a few days at a time, not for
12 a whole week or so. So I can obviously agree to a four-day
13 deadline, I think, written down.

14 DR. LICHTENSTEIN: Same situation.

15 DR. GRUNDY: Just the end of this month and from
16 the end of May for about an eight week time.

17 CHAIRMAN GARZA: Okay, so the end of March the end
18 of May. Are there working groups that Scott shares where
19 those dates are going to be a problem?

20 I've not heard any because the only other real
21 extended time would be Richard, and I don't think those
22 dates coincide with when you're going to be away.

23 DR. DECKELBAUM: One of them does, the last week
24 in March.

25 CHAIRMAN GARZA: Okay. All right, maybe that
26 would be the only -- the only time we'd have two people
27 away.

28 Okay, great. Then why don't we begin then with
29 the working group, and I've got to get my agenda.

1 Eat a variety of foods, you could do it from your
2 places or using the lectern, whatever you feel is most
3 appropriate.

4 DR. MURPHY: All right, our working group has been
5 looking at the variety guideline and trying to reincarnate
6 it as an adequacy guideline, and after some discussion among
7 yourselves and with some of our colleagues, it looks like
8 we'd still like to try to link the adequacy to the food
9 guide pyramid because that is indeed the primary federal
10 vehicle for offering guidance to the public.

11 But that, of course, raises some issues of
12 circularity because the pyramid is based on the guidelines
13 and the guidelines won't be set until this committee has
14 completed its work. And then if we want the pyramid to be
15 part of the guidelines, how mechanically or logistically can
16 that be worked out.

17 So what we have are several issues that need to be
18 explored over the next few weeks with a variety of people
19 and resources that we'd like to take advantage of.

20 For example, what would be the possibility of
21 integrating the current food guide pyramid into the dietary
22 guidelines as they come out initially, and then at a later
23 time change the food guide pyramid, if it is changed, if
24 USDA finds a need to change it based on the new DRIs or the
25 new guideline? What would be the mechanical process that
26 would need to be followed to update the pyramid which now
27 would be already be in the dietary guidelines booklet?

28 So the federal people have agreed to work with us
29 to try to come up with some approach that would be feasible,

1 and I think one option being discussed, for example, is
2 perhaps, if necessary, the booklet would be reprinted if
3 there was a change, a significant change in the pyramid
4 itself.

5 So we're trying to work through some of these
6 issues so that there is an integrated approach to
7 nutritional adequacy that is communicated to policy people
8 as well as the public that integrates both the guidelines
9 and the pyramid, and I personally am a big believer in
10 trying to make our guidance look like it all came from the
11 same intellectual body of knowledge, so it would be nice if
12 we could do that, and we certainly intend to pursue it.

13 A couple of other things we also would like to
14 investigate further. We'd like to have the guideline offer
15 more flexibility to consumers on how to design an adequate
16 diet. The pyramid gives perhaps a basic structure, but we'd
17 like to clarify that the pyramid can be used by a variety of
18 groups and by a variety of -- for a variety of purposes.

19 So, for example, we would like to keep certainly
20 the section in there that talks about vegetarian diets and
21 maybe even slightly expand some of the options, for example,
22 for people who are lactose intolerant or people who don't
23 consume animal products at all, what would be options for
24 getting enough calcium.

25 We might consider adding more on cultural
26 preferences for people of different backgrounds or different
27 culinary interests that want to adapt the pyramid for their
28 purposes. All this information, of course, is available,
29 but we think that perhaps more of it should be pulled into

1 the dietary guidelines booklet so that people see the
2 pyramid as one of -- as a guideline to many ways of
3 implementing a nutritionally adequate diet.

4 And another thing that we would like to do is to
5 incorporate an expanded text on fortified foods and
6 supplements that reflects more a scientific consensus that
7 these foods do have a place in a nutritious diet, and, of
8 course, there is a whole group working on how that text
9 might be in there, but I think we're all in agreement that
10 it needs to come under the umbrella of this particular
11 adequacy guideline.

12 So those are the main issues within the guideline
13 itself. We're also interested in trying to work out what
14 goes into the introduction and what goes into the adequacy
15 guideline itself, and it's my understanding, Dr. Garza, that
16 this group will be trying to make those decisions with your
17 help.

18 CHAIRMAN GARZA: Yes.

19 DR. MURPHY: So we've recruited another member to
20 our working group, Roland, it's not just us now.

21 DR. WEINSIER: One more won't hurt.

22 DR. MURPHY: Because it may be we want the
23 separation between the two parts of the booklet to change
24 somewhat based on the new concept of adequacy.

25 And, of course, variety is not going to go away.
26 We still believe that variety should be a cornerstone of a
27 nutritionally adequate diet, and so text on variety we would
28 like to keep and would actually like to continue it as a
29 theme and we'll be looking into ways to continue to focus on

1 variety, even though at this point it probably will not be
2 in the wording of the guideline itself. And that's it.

3 CHAIRMAN GARZA: Okay, thank you.

4 In response to that I've asked the group -- I'll
5 ask the group to think about the -- how the pyramid is in
6 fact constructed, so we'll be asking -- Shanthi, if you'll
7 remind me to make sure that we have somebody at this next
8 meeting that will review with the group what actually goes
9 into the construction of the food pyramid, remembering that
10 it is not only the dietary guidelines but DRIs and
11 consumption patterns.

12 One of the attractive aspects of what the group
13 proposes is as DRIs, for example, change and the pyramid is
14 reconstructed based on those recommendations, then it does
15 provide us a mechanism to remain the currency of this
16 between meetings of this advisory -- of the advisory group
17 for the dietary guidelines, because as DRIs are done, that
18 in fact the pyramid can be examined.

19 It also is clear, however, in our discussions that
20 it will be increasingly important that this group consider
21 making or calling -- asking the secretary's attention to be
22 focused on the need to have much better across-departmental
23 collaboration and cooperation in the construction of the
24 pyramid, so that, in fact, it reflects health as broadly as
25 possible from both the USDA and the HHS perspective.
26 Because if we're going to make it as central a part of the
27 guidelines as the working group has suggested, then just as
28 it is important to make sure that the pyramid remains
29 current in terms of DRI consumption patterns and the latest

1 dietary guidelines, then assuring ourselves that it meets
2 the broad concerns of both departments is very important, so
3 that the group should try to see whether or not we could
4 have language to that effect and speak to both departments
5 in terms of the strength and weaknesses they see in the
6 current process.

7 Okay, are there any other comments or questions to
8 any of the working group?

9 Meir.

10 DR. STAMPFER: I'm -- I have serious doubts as to
11 whether the aim of achieving the guidance that you talked
12 about -- you had a very elegant phrase for it, but giving
13 people alternatives and that sort of thing -- can actually
14 square well with the food guide pyramid. I think the way
15 that the food guide pyramid is constructed it is set forth
16 in a very prescriptive way. Choose two to three servings
17 of dairy, choose two to three servings of the quote "meat
18 group," and I don't know if the -- I certainly agree with
19 your goal about relaxing the prescriptive nature, but the
20 way it's set up now it's -- I don't know if it really can,
21 if we can use that as the guide if we really want to change
22 that tone.

23 And, in particular, what's wrong with the pyramid?
24 I think there are several things wrong with it. It
25 advocates a high carbohydrate, low fat diet with the
26 carbohydrate at the base without attention to the quality of
27 the carbohydrate. We know that this kind of pattern can
28 lead to metabolic disorders and increased clinical outcomes.
29 It advocates meat and animal products, and it puts meat

1 together with fish, beans and nuts in one group without
2 regard to the different health effects of those -- of those
3 foods. It advocates restriction of polyunsaturated and
4 monounsaturated fats. It includes potatoes as a major
5 vegetable. I think there are some serious flaws in the
6 pyramid, and I think we should be cautious about using that
7 as a basis for our recommendation.

8 CHAIRMAN GARZA: Remember that the pyramid is
9 based on the dietary guidelines in part. To the extent that
10 the guidelines change, the pyramid will have to change, and
11 that Suzanne also said that in fact they would be giving
12 alternatives within the text so that if, for example,
13 someone wants to meet their calcium needs with other than
14 lactose-containing foods, then that would be included.

15 I don't know whether any icon would be able to
16 satisfy the broad needs of every single eating pattern in
17 the country. If I go to my own region, I'd like to see a
18 tortilla there instead of perhaps a glass of milk. There is
19 just as much calcium, but not everybody enjoys them as much
20 as I do.

21 DR. GRUNDY: Do they have tortillas up in New
22 York?

23 CHAIRMAN GARZA: Actually, they do; very good
24 ones.

25 (Laughter.)

26 CHAIRMAN GARZA: I think they import them from
27 Texas. They are good. We get them flown in actually, but
28 that's another story.

29 (Laughter.)

1 CHAIRMAN GARZA: So I think that's -- i didn't see
2 anything incompatible with what you were saying in terms of
3 trying to recognize some of the shortcoming and the options
4 that Suzanne was offering us.

5 Did I misunderstand what you were saying?

6 DR. MURPHY: No, and I'm certainly in agreement
7 with Meir's concern about the food guide pyramid appearing
8 prescriptive. I mean, I would like it to be interpreted by
9 consumers as a guide, but not a prescription. And if there
10 is a way we can address that in the text, I would appreciate
11 help from anyone that can offer it; you, in particular.

12 CHAIRMAN GARZA: Johanna and then Roland.

13 DR. DWYER: I wanted to urge that somehow the
14 concept of food security get in the first part. The reason
15 for that is because I know that elsewhere in the U.S.
16 Department of Agriculture, with the support of a number of
17 voluntary and professional associations, and they developed
18 a measure of food security, and I think it's very important
19 to try to tie that in.

20 And just as you just urged, Dr. Garza, that there
21 be extensive consultation across departments with respect to
22 this pyramid, also there should be consultation perhaps
23 across departments on that.

24 In terms of the ethic diversity and different
25 culinary traditions idea, I heartily endorse that too, and
26 in reference to Dr. Stampfer's questions and comments about
27 his concerns about some aspects of the pyramid, I think I
28 heard a presentation by someone who may be here this morning
29 some years ago. It was by Dr. Susan Welch, who showed how

1 the pyramid could be interpreted even to fulfill the old
2 ways Harvard pyramid. It isn't as prescriptive as that it
3 seems to some observers.

4 CHAIRMAN GARZA: Roland.

5 DR. DECKELBAUM: Yeah, I appreciate and basically
6 agree with Dr. Stempfer's comments. I'm not sure that what
7 Dr. Murphy is presenting is substantially different. The
8 risk is not knowing what the pyramid will look like.

9 Do we have the option to approach this -- we being
10 the subcommittee and the whole committee -- to propose this
11 guideline on the basis of the emphasis within other
12 guidelines?

13 For example, if we're talking about the grains
14 group, if we're talking about whole grains, if the pyramid
15 doesn't reflect that, or if we're talking about the dairy
16 group and make some verbal descriptions. If the pyramid
17 doesn't reflect that, do we have the option to not include
18 the pyramid and perhaps change the title at that time,
19 instead of, you know, "Let the pyramid be your food guide,"
20 I mean -- yeah, then perhaps revert to something like
21 "Choose from the five basic food groups" or something like
22 that? Do we have the option --

23 CHAIRMAN GARZA: Dr. Roland, the problem with that
24 is the following. It's very difficult to construct total
25 dietary advice based on the guidelines because it doesn't
26 address nutrient adequacy very broadly, and that's why I
27 think it's important not to lose sight that the departments,
28 and I would have put an "s," not the department, but I hope
29 the departments, have the challenge of bringing together the

1 dietary advice this group has with all of the DRIs, and then
2 to try to make it compatible with as many consumption
3 patterns in the country as possible.

4 Now, if this gourd wants to take it upon itself to
5 also develop the DRIs, make sure they get incorporated --

6 DR. MURPHY: I resign.

7 CHAIRMAN GARZA: I would resign. We both have
8 been involved with that.

9 It's just not practical. I mean, for us to then
10 say --

11 DR. DECKELBAUM: I'm not sure that --

12 CHAIRMAN GARZA: -- we're not going to approve our
13 pyramid until we get to see it. I think it would be very
14 helpful if all of us had an opportunity to hear what goes
15 into it because it doesn't represent the work of only this
16 group. It represents the work of an entirely different
17 process, plus the work of this group. And so I don't think
18 that it's going to be feasible to give advice, it says.
19 You know, we're not going to even mention this unless we get
20 pre-approval, and I'm being very frank with the group. I
21 just don't think that's going to happen, but I think it's
22 reasonable.

23 I mean, I understand the reasons why it can't
24 happen. I don't think it's an agency that's being difficult
25 to work with. I think it --

26 DR. DECKELBAUM: I wasn't suggesting that we ge
27 pre-approval. I mean, we discussed that at length
28 yesterday.

29 CHAIRMAN GARZA: Well, how would you then --

1 DR. DECKELBAUM: No, I was asking if there is the
2 option, because as Suzanne was suggesting, you know, even if
3 a new book needs to be reprinted, I mean, that's a major
4 change at, you know, the last minute. I was asking if the
5 pyramid does not reflect what the consensus of this group
6 was, do we have the option -- I'm asking -- do we have the
7 option to not include the pyramid within the guidelines?

8 CHAIRMAN GARZA: What I'm asking is how do we get
9 to nutrient adequacy though without something that has as
10 much work as presumably the pyramid has with both
11 departments? Because if we say "just choose from the five
12 food groups," I mean, you have to have a lot more detail than
13 just "choose from the five food groups" to make sure that
14 you get iron and you get protein and you get calcium and you
15 get zinc and you get all the other nutrients other than just
16 fat, carbohydrates, and fito chemicals in the diet. That's
17 the challenge.

18 Shirika.

19 DR. KUMANYIKA: I think that for this subcommittee
20 the issue to consider is that no guidance we give means
21 anything unless we tie it to choices from the foods that are
22 available. I mean, that's what we're actually trying to do
23 with the pyramid. It's the current form of food guidance
24 that's based on food groups. And so to that extent it
25 sounds like you're telling people to choose from food groups
26 because you are, because that's where you're going to get
27 your nutrients from.

28 So the alternative would be to then propose
29 another listing of commodity food groups as an alternative

1 to the pyramid, and I don't think we want to get into that
2 because that has implications that we're going to -- as Bert
3 says -- to go beyond the pyramid.

4 So I think if think of the text as reminding
5 consumers that any kind of dietary guidance has to be
6 filtered through food choices and that this is a pattern for
7 it, maybe with the language about different preferences and
8 more explanation of what those foods represent, foods that
9 provide calcium and so forth, foods that provide protein, it
10 may take a little bit of the onus off of naming the group
11 only by its commodity category, but also talk about the
12 underlying nutrient base of those foods.

13 CHAIRMAN GARZA: Yeah, yeah.

14 Scott and then Alice.

15 DR. GRUNDY: I have a technical question about the
16 structure of this committee and how it might relate to this,
17 and I'm not ever quite sure about that.

18 As I understand it, this committee is a -- it's an
19 advisory group to the departments, but it's not linked to
20 the departments directly. I mean, I think that what we say
21 then is made available to the public, and they could build
22 any kind of pyramid they want to out of what we say,
23 couldn't they?

24 I mean, we're not just giving -- in other words,
25 these guides are not government guides, are they? The
26 government is not telling the public what to eat, I don't
27 think?

28 CHAIRMAN GARZA: Our green report is not this.
29 The government produces this based on the green report.

1 DR. GRUNDY: That's right. And I have some
2 concern about linking us so closely to the government that
3 would be done here; that, in essence, we are in cahoots with
4 the government in the sense of telling the people what to
5 eat. You know, I'm just raising that from a technical point
6 of view.

7 CHAIRMAN GARZA: Well, I mean, the problem that I
8 see, and I -- is that we can't have it both ways. We can't
9 provide guidelines that are unintelligible to the public.

10 DR. GRUNDY: No.

11 CHAIRMAN GARZA: And we can't -- so that we have
12 to provide some mechanism to have the public be able to
13 implement them.

14 Now, we can decide, as has been -- as we're
15 discussing, that the pyramid is not the appropriate way of
16 doing that, and we'd like to disassociate any advice we have
17 from the pyramid, or we can say, you know, we recognize this
18 as part of the process. There is an element of trust that
19 in fact government will do its work well in incorporating
20 all three: the dietary guidelines, nutrient requirements
21 and make them achievable by paying attention to consumption
22 patterns, and the example that we used was kale, because it
23 came up in our discussion; that we might be able to say, you
24 know, "America, forget milk, you know; take kale." It's not
25 going to happen.

26 I mean, what we can do is in the text say, you
27 know, that there are alternate forms for calcium and include
28 kale with many others, and that may be appropriate.

29 Let me go to Alice, Meir, Richard, and then Rachel

1 and then Suzanne, and Linda. Okay.

2 DR. DWYER: Forget about the 2:00 planes.

3 CHAIRMAN GARZA: I hope you all remember that
4 order because I probably will not.

5 DR. LICHTENSTEIN: I came into this meeting
6 actually quite skeptical about including the food pyramid
7 and tying the guidelines to the pyramid for a lot of the
8 reasons that were articulated and also because of my
9 focusing on supplements and that you've got certain foods
10 that somehow now don't fall into any category if they're
11 going to be linked to nutrients.

12 After hearing all the discussion, I have actually
13 gotten to the point where I am in favor of including the
14 pyramid because of understanding exactly what goes into it,
15 but also realizing that these guidelines alone are really
16 not actionable, and that a lot of the concerns that have
17 been raised are already addressed in this book, and maybe
18 what we need to do is strengthen it. Because if you look at
19 page 10 and 11, Box 3 and 4, good sources of calcium cuts
20 across at least three or four food categories, and good
21 sources of iron is cutting across a lot of those boxes
22 actually within the pyramid, and I think there are examples
23 of that throughout the text.

24 But the food pyramid as we were informed is what
25 people recognize. It's what people see, and certainly it's
26 been picked up in a lot of ways that perhaps would not have
27 been predicted because it's not just perpetuated by the
28 government, but you see it on the back of cereal boxes, you
29 see it in lots of educational materials that are in the

1 school systems right now.

2 I think what we need to do is work within it,
3 round it, and message it maybe a little bit.

4 DR. STAMPFER: I just wanted to echo and follow on
5 what Scott was saying.

6 This is not our product. This is the product of
7 the government. Our product is the green report, and to
8 that end, I think we can give our best advice according to
9 the guidelines that we feel are appropriate, and the
10 government, in its wisdom if they wish to choose to add in
11 the food pyramid when they create this document, is
12 perfectly free to do so. But I don't think that we're
13 necessary bound. I think it's good to have that degree of
14 separation.

15 CHAIRMAN GARZA: But let me press you a little
16 bit.

17 DR. STAMPFER: Sure.

18 CHAIRMAN GARZA: How would you then suggest that
19 we recommend or advise the government that it make these
20 actionable? I mean, one can say, look, you know, construct
21 a pyramid with the guidelines that puts together and then
22 hope that in fact that's carried out, because I -- the
23 alternative of saying, well, you know, don't follow our
24 advice, or don't pay attention to other nutrient
25 requirements, or don't pay attention to prevailing
26 consumption patterns might be the implicit message we'd be
27 giving by saying we don't think that we have to worry about
28 making them actionable.

29 Now, am I -- so I don't see how we can ignore it

1 is giving some advice to say either we think the pyramid as
2 an actionable item should be discarded and we want to go
3 back to the five food groups, but sort of burying our heads
4 in the sand and saying this is not our concern, I think,
5 would be a dereliction of some of our responsibility.

6 So if we feel strongly about it, we ought to
7 tackle it in our advice to say that we think whatever icon
8 is used should meet certain characteristics, or endorse it.
9 I hope --

10 DR. GRUNDY: There is two different things.
11 Saying that it meets certain characteristics is one thing,
12 and I'm not opposed to that; I think that's good. To
13 endorse that --

14 CHAIRMAN GARZA: No, but that's --

15 DR. GRUNDY: -- ahead of time, that's where I have
16 some --

17 CHAIRMAN GARZA: Well, what I heard Suzanne saying
18 was that whatever pyramid was constructed would meet the
19 characteristics we've been told it's based on.

20 DR. GRUNDY: We certainly hope so.

21 CHAIRMAN GARZA: Did I misunderstand that?

22 DR. MURPHY: Right.

23 CHAIRMAN GARZA: So it's not, you know, we would
24 recommend any pyramid regardless of how closely it adheres
25 to the guidelines or not, that it should adhere to the
26 guidelines, the DRIs, and pay attention to consumption
27 patterns because that's what makes it actionable.

28 DR. WEINSIER: That was my question, so you did
29 answer it by saying yes then, that it will reflect these

1 guidelines because I thought that's what I was asking.

2 CHAIRMAN GARZA: Yeah, but that's what we've been
3 told repeatedly is what it's based on. Now, what I can't
4 guarantee is that we would be given approval to say, now,
5 does it meet those three requirements. I can't -- I can't
6 give you that assurance.

7 But, I mean, so I'd like you to elaborate a bit
8 more. I mean --

9 DR. STAMPFER: Okay, yeah, I'll try to do that.

10 I think even the advocates of linking the food
11 guide pyramid with the guidelines have expressed some
12 reservation with some of the aspects of it in terms of say,
13 at least the prescriptive nature or, in my view, a more
14 fundamental issues. So that I think there -- there is at
15 least in a subgroup of this committee a sentiment that we
16 would not accept absolutely as written in its present form
17 the food pyramid as our guide.

18 So if the question is do we endorse this fully or
19 we reject it, and there is nothing in between, you know,
20 then, you know, maybe we should consider that. But I think
21 the in between approach would be to give our best advice
22 regarding the dietary guidelines and then the government and
23 the departments can decide how they're going to construct
24 the food pyramid, which is beyond our purview anyway.

25 CHAIRMAN GARZA: Let me pursue that. I am being
26 dense and I apologize. We can't ask -- we can't ask the
27 group to endorse something that doesn't meet the guidelines
28 we're going to come up with. I mean, that's sort of a -- I
29 mean, it's so self-apparent that I hope that that was never

1 being considered by anyone. So that when we say -- when
2 Suzanne is saying "follow the pyramid," it's the pyramid
3 that coincides with the guidelines we're going to be coming
4 up with, and that's the dilemma she presented, to make sure
5 that, well, how do we -- how do we do this. I mean, it was
6 recognized as an issue.

7 It isn't, "We will endorse any pyramid whether it
8 meets these guidelines or not." So I'm -- that's where my
9 confusion is coming; that I keep coming back to the idea
10 that the pyramid has to meet three criteria. The dietary
11 guidelines is one. Now, when we make recommendations, you
12 know, those guidelines will presumably change. The second
13 is the DRIs, and the third is the consumption patterns, and
14 that's what we are asking, you know, can we approve things
15 that meet those three, and that would then meet with what
16 the committee wants -- the subgroup wants to do.

17 Am I the only one that's confused?

18 DR. GRUNDY: Let me comment on that.

19 I think it's -- I agree with what Meir says as a
20 conceptual thing. I think there is also the problem is that
21 the pyramid are not the guidelines.

22 CHAIRMAN GARZA: That's right.

23 DR. GRUNDY: They are not -- but yet there is a
24 danger that they can be taken so literally as to be the
25 guidelines if we endorse it and say "eat that," then they
26 superseded almost what we've done, and in the minds of the
27 public they become the guidelines as what --

28 CHAIRMAN GARZA: The dilemma is this, Scott, that
29 the public doesn't -- right now doesn't -- is not aware of

1 the guidelines to the same degree that they are aware of the
2 pyramid because it's a simple teaching tool. And so what we
3 can do is say, "Government, forget the pyramid as a way of
4 teaching the guidelines."

5 DR. GRUNDY: That might not be a bad idea.

6 CHAIRMAN GARZA: Well, that what --

7 DR. GRUNDY: I mean, I think that --

8 CHAIRMAN GARZA: -- I'm trying to get at. We
9 can't have our cake and eat it too is what I'm saying.

10 DR. GRUNDY: I do. I think this is better than
11 this. I mean, that's -- because I think that the concepts
12 and the flexibility does exceed that.

13 CHAIRMAN GARZA: Okay, well --

14 DR. GRUNDY: And I don't think the public knows
15 that.

16 CHAIRMAN GARZA: Suzanne and then --

17 DR. MURPHY: May I go out of order --

18 CHAIRMAN GARZA: Yes.

19 DR. MURPHY: -- as chairman of the subgroup,
20 please? And I'd just like to respond to Scott's comment
21 about we seem to be endorsing or getting too close to
22 government process here.

23 I'd like to suggest that the development of the
24 pyramid is a process that anyone can follow. It happens to
25 be a process that's assigned to USDA. But USDA doesn't do
26 this in a vacuum. They are supposed to be doing it in
27 consultation with this committee, with the DRI committee,
28 with the other agencies of the federal government.

29 I think it is a good process and if we don't like

1 the process, then I think we should be giving feedback to
2 them that the process is not working, but I don't think we
3 need to look at the pyramid as a government product. It's a
4 product of a consensus of the whole scientific community, of
5 which the Dietary Guidelines Committee is part.

6 Let's have a speaker at our next meeting. Let's
7 understand better how they get generated. And if we
8 disagree with that process, if we don't think it's working
9 right, then let's say so. But let's not reject the end
10 product of a process because we haven't given enough
11 feedback on the process itself.

12 CHAIRMAN GARZA: Okay. Let me finish on this side
13 and then we'll come to this. Anybody?

14 Johanna, did you have your hand up or not?

15 DR. DWYER: I just -- I think I basically still
16 feel that it's important to have the pyramid in there, but
17 the fundamental thing is that this is not 1940 and the
18 Ministry of Food in Great Britain where what we're doing is
19 prescribing or dictating a national diet. The First
20 Amendment allows anybody to make an alternative pyramid; in
21 fact, many have made many pyramid that are alternative. So
22 this is not dictating what people will eat the way we would
23 be under food rationing or something. This is a set of
24 actionable recommendations that people can take or throw
25 away, and usually, unfortunately, they take the latter
26 course.

27 CHAIRMAN GARZA: Richard, and then we'll go down
28 this and that.

29 DR. DECKELBAUM: Just two points. One is, you

1 know, what's the mission of this committee. We're part of a
2 broad initiative to improve health in the United States and
3 the American people through a key lifestyle which is
4 nutrition and also exercise. And our job is to provide the
5 science base or the evidence base for that. But the only
6 way this is going to happen is if this is done in
7 partnership with the government and in partnership with
8 industry,

9 So that if our science suggests that for reason QY
10 that every home needs a minus 70 freezer so that we can
11 implement this and that in that subgroup, we know that
12 that's going to be totally impractical. And even if the
13 science is there, you know, it's not a good thing to come
14 out as a major recommendation of this committee.

15 If we look in this current thing, this pamphlet,
16 it's not a thing, the food guide pyramid serves as an
17 educational tool, okay. Now, a number of us have been in
18 different organizations that make educational tools, and
19 when you make an educational tool like the slide set, the
20 slide sets are designed so that they can be used by multiple
21 users in different ways, so that you can get multiple
22 messages across for that tool.

23 So I'm going to take a specific example of the
24 current pyramid. So that, for example, if someone wanted to
25 give a talk and say that potatoes are not the optimum or
26 preferred vegetable, they could point to the current pyramid
27 and say, "Look, compared to the other vegetables that are
28 depicted, potatoes actually occupy a very small amount of
29 space." It's there, but -- no, but you can do that.

1 Notice that we have two to three servings of dairy
2 products a day. There are other ways to get your calcium
3 and other nutrients that are -- so basically it depends on
4 how you use the slide, if you will, and I think that's what
5 we're talking about. There are multiple ways that this
6 slide or this pyramid can be used as long as you give the
7 verbal message, either in oral presentations or as long as
8 you do it in the text in a decent way.

9 But at the moment this so far, and the feedback
10 that we get from other groups is that this is a decent
11 educational tool and it's been effective. So how we modify
12 it, it could be better, and slides, you know, slide sets are
13 revised every few years. But I think that we've got to
14 realize that the major effect of developing there, to sort
15 of destroy it one shot would be, I think -- would be harmful
16 to steps that have been made in a positive ways towards
17 improving nutrition in the United States, and we have to be
18 very careful, but it is an educational tool. It's not the
19 guidelines and we've all agreed upon that.

20 So I think we have to take that into
21 consideration, and I would urge those of us who want to use
22 it in different ways, that you can use it. I use it in
23 different ways when I teach, and it's very -- you can use it
24 for all -- as I said to a small group yesterday, you can use
25 the current pyramid basically in most of the discussions
26 that we've been talking about. You can talk about the base
27 in whole grains. You know, it's hard to tell if this loaf
28 is from a whole grain or refined grains, but you can make
29 the point when you are going through that.

1 And I think that also in thinking of the link of
2 this educational too with what we're going to be writing is
3 that in some of the areas there are controversy, so that
4 it's not universally accepted that this type of nutrient
5 predisposes to this kind of disease versus that kind, so
6 that there are controversies still in the field, and we have
7 to have a tool which allows controversy to be discussed even
8 when the tool is up there.

9 I mean, I would say that people who might not
10 agree, for example, on the type of sugar or carbohydrate,
11 could effectively use the pyramid for, you know, that kind
12 of argument on either side. It's just a tool.

13 CHAIRMAN GARZA: Rachel. I'm sorry.

14 DR. DECKELBAUM: So I think we've got to be very
15 careful in total disassociation of something that's so
16 recognized by a large segment of the population. What we
17 have to do is explain it better.

18 CHAIRMAN GARZA: Thank you. Rachel.

19 DR. JOHNSON: I'll be brief.

20 I'd just like us to -- I'd like to urge us to
21 remember what Dr. Kennedy said several times when she was
22 here, which is we need to think about adequacy of the
23 guidelines as well as current consumption patterns in the
24 population.

25 For example, we know that 75 percent of the
26 calcium in American's diets is obtained from dairy products.
27 We know from our research that children who do not include a
28 source of milk in their diet do not come close to meeting by
29 the calcium recommendations. They are not substituting, by

1 and large, on average, other high calcium products.

2 So I am just urging us to try to get away from
3 this good food/bad food approach that I'm very concerned
4 that we're taking. Think about good diets versus bad diets.
5 And think about what is practical and achievable for the
6 U.S. population given current consumption patterns, because
7 the quickest way to have the guidelines totally discounted
8 is to come up with something that is so far removed from
9 current consumption patterns that it won't be acceptable.

10 CHAIRMAN GARZA: Roland.

11 DR. WEINSIER: I didn't have my hand up.

12 CHAIRMAN GARZA: Shirika.

13 DR. KUMANYIKA: I have three comments.

14 One is that we might make the point that people
15 should have a dietary pattern, and by that I mean, similar
16 to what Rachel just said, that ad hoc exchanges might not
17 work for people. I mean, that that -- you know, there is a
18 dominant consumption pattern, and people who have a
19 different pattern should make sure that that pattern is
20 adequate. If we could get that concept in there so that we
21 avoid the idea that people really will do ad hoc
22 substitutions and not have an adequate diet.

23 The second comment is that I'd like to see us
24 include three of the graphics for the different calorie
25 levels, or I have something I can send to you or to Carol
26 that I did for a clinical publication, and that could be
27 used to make the point that there are different calorie
28 levels for different types. It's in the text but it's not
29 graphically shown.

1 And the third suggestion is that we include the
2 pyramid annotated. This picks up on Richard's comment. We
3 can show how the dietary guidelines relate to the pyramid,
4 if we can do it without being too busy, by pointing out that
5 within the grain group we will be suggesting a certain type
6 of grain product to be emphasized within that. I'm thinking
7 of some sort of arrows or call-outs around a pyramid that
8 show how this basic eating pattern relates to the dietary
9 guidelines.

10 CHAIRMAN GARZA: I think what the gourd is saying
11 is come up with some alternative ways, one of which is a way
12 that one might be able to use the pyramid, but think of at
13 least one alternative way. The food groups has been
14 suggested as one alternate way. Another one is not to
15 necessarily tie it to the icon, but to say whatever teaching
16 tool is used see if it can meet these sorts of criteria. Or
17 alternatively, is it possible that in fact one could include
18 multiple pyramids to look at not only various calorie
19 levels, but perhaps different eating styles; one that would
20 really minimize dairy and meats to a greater degree because
21 a growing proportion of the population is choosing that
22 dietary pattern, and how would you do that in a way that
23 also meets dietary, dietary or nutrient needs, and perhaps
24 we could have more than one pattern depicted so that we
25 don't appear quite as prescriptive.

26 Did that capture all of the various ways that have
27 been suggestions that might be actionable?

28 Okay, then let's move on then to the next
29 guideline which hopefully will, you know, as planes

1 disappear in the horizon. All right, we're going to be
2 going then to choose a diet with plenty of grain products,
3 vegetables and fruits.

4 DR. WEINSIER: No, you skipped one.

5 CHAIRMAN GARZA: I sure did. Balance the food you
6 eat with physical activity.

7 DR. WEINSIER: Basically, these are points that
8 came out of our discussion yesterday and would like to pose
9 to the committee for consideration.

10 Under the weight guideline, tentative going to
11 weight guideline, I think we discussed and a number of
12 people presented yesterday to remind us that one of the few
13 year 2000, HHS year 2000 goals was to not increase the
14 prevalence of obesity, and this is one of the few such goals
15 which was only not achieved, but was going in the wrong
16 direction. We've heard that approximately 25 percent of the
17 pediatric population and 50 percent of the adult population
18 are now in the overweight or obese categories. And we've
19 heard that genetic factors cannot account for the rise in
20 prevalence in obesity, but rather, are responsive to a
21 changing environment.

22 So with that as a very brief background, the
23 changes that we've considered and I'd like to suggest to the
24 committee in this guideline are, first, regarding the title
25 or the focus, and the previous title, as everyone probably
26 recalls, is "Balance the food you eat with physical
27 activity: maintain or improve your weight." And we
28 discussed some of the limitations or concerns from focus
29 group analyses about that guideline, particularly the

1 definition of "improve," and also some concern about the
2 word "balance" and the understanding of the word "balance."

3 A suggestion that our subcommittee would like to
4 make for the full committee would be to consider a title
5 that's perhaps shorter, more actionable, "Achieve a healthy
6 weight." This is just one that we're posing for
7 consideration and to try on to see if it fits. The
8 justification for this recommendation is to maintain a
9 current weigh may be a goal for the population as a whole,
10 but for the individual, in other words, if we're looking at
11 the year 2010 goals, sure, to maintain current body weight
12 may help us meet that goals, but getting to an individual
13 level that the guideline is to help guide toward maximum
14 health benefit, which is expected to be achieved by reaching
15 an ideal body weight or a quote "healthy" weight.

16 The reason for considering omitting the second
17 half of the recommendation or one-half of the
18 recommendation, which is "Balance the food you eat with
19 physical activity," is that the subcommittee has recommended
20 to the full committee developing a separate section, as Dr.
21 Garza alluded to earlier, that focused on physical activity.
22 If that were taken out of this guideline and put in as a
23 separate guideline, then we probably don't need it in the
24 title. In other words, we could say, "Achieve a healthy
25 weight" and take out the part about "Balance the food you
26 eat with physical activity."

27 The reason for suggesting take the physical
28 activity out are for the reasons Dr. Garza enumerated
29 earlier, but they include the fact that physical activity is

1 a very, very important lifestyle. It impacts on various
2 ares of health, not just weight, but they include risk of
3 cancer such as colorectal cancer, cardiovascular disease
4 health, increase total energy intake or enable total energy
5 intake to increase, which can improve options for overall
6 health.

7 Now, with regard to the second issue, the
8 definition, the definition of a healthy weight, we'd suggest
9 a -- probably a fairly small but, I think, important change,
10 and that is to use the BMI, or Body Mass Index, to emphasize
11 that in this guideline, reinforcing, one, the public's
12 recognition of this term "the Body Mass Index," which is
13 being used more and more often, and allowing ease of
14 comparison across guidelines, because now we have other
15 published documents, such WHO and the NIH guidelines and the
16 AOA guidelines that are incorporating the Body Mass Index.
17 So using that term, I think, will make it a little more
18 friendly -- user friendly and perhaps a more appropriate
19 guideline.

20 The current reference, as you may recall on page
21 18, is to Figure 3, which shows is color form a graded
22 relationship between weight and height. It is based upon
23 BMI so that's not a divergence I'm suggesting from the past
24 guideline, but we could consider still using this perhaps
25 with introduction into some of the shaded areas the BMI
26 range, so that way we reenforce the BMI, but not necessarily
27 giving up the past figure that was used.

28 The thing that I do like about this figure is it
29 showed a graded approach. There is nothing new in this

1 area. We will want to emphasize to the public that going
2 from one category of BMI to another doesn't meant you're
3 healthy, you're not healthy, you're normal, you're abnormal.
4 It's a graded approach and we'd like to try to work, if
5 Carol and others can help us, come across with that point
6 that it's a graded thing. Coming closer within the healthy
7 range of BMI is probably better but there is no absolute
8 cutoff.

9 A disadvantage of using this current description
10 is one, the titles would have to be changed because they
11 don't match up. The words "moderate, overweight, severe
12 overweight" really don't match with the going terms, but I
13 don't see that has a major hurtle. A disadvantage, in
14 addition to that, is that it does not include reference to
15 waist circumference as an independent marker of health risk
16 related to body weight and body fat distribution.

17 That point being made, we may want to still
18 consider going to an alternative approach which would
19 actually refer to the various BMIs and the categories, but
20 then brings in the impact of waist circumference, this being
21 normal waist circumference, this being higher waist
22 circumference, and then demonstrating relative risk of
23 disease, hoping perhaps that with something like arrows or
24 terms, Carol again may have to help us, trying to imply that
25 this is a graded sort of change, that as your weight gets
26 higher and if your waist circumference is higher, then your
27 risk gradually increases as a population. So we need your
28 input and thoughts, but those are options that we would like
29 the whole committee to consider in terms of definition of a

1 healthy weight.

2 The next thing was weight goals. We would like to
3 reemphasize, not change, but reemphasize what is in the 1995
4 guideline, the importance of prevention in increasing the
5 current average body weight, the prevention of a BMI greater
6 than 25, and avoidance of further weight gain. So I don't
7 want to distract from the importance of, regardless of your
8 weight, try not to increase your weight. I think that needs
9 to be reemphasized primarily for the individual who's not
10 currently overweight to emphasize the importance of
11 prevention.

12 Secondly, to provide guidance on who should lose
13 weight and who may not need to lose weight. This is, again,
14 reenforcement of what was in the 1995 guideline, perhaps
15 just fine tuning it according to recommendations of the WHO
16 and the NIH reports.

17 Thirdly, to reenforce the 1995 recommendation of a
18 five to 10 percent weight loss, improving overall co-morbid
19 conditions, I think that needs to be emphasized, but in the
20 context of not stopping there, but to add, and I'm asking
21 for the committee to consider that we add to that
22 recommendation of the benefits, health benefits of a five to
23 10 percent weight reduction if you're overweight, to
24 emphasize the point that medical risk may be maximumly
25 improved by achieving a healthy weight. The justification
26 for this is that they do show a graded approach.

27 It's not as if you lose five or 10 percent and now
28 you're completely health and removed all of your risk. It
29 may or may not. Generally if the population data hold for

1 the individual, that achieving an ideal body weight or
2 healthy weight would maximally improve the health. This
3 would go along with the current report of Clem, et al, from
4 the Weight Loss Registry, and with the NHLBI guideline of
5 last year.

6 Fourth, with regard to the weight loss approach,
7 reenforcing, not necessarily changing the emphasis of the
8 1995 guideline on a healthy lifestyle versus diet, implying
9 that we're trying to establish patterns for good health
10 which include behavioral modification, practices, sound
11 dietary practices compatible with the other guidelines
12 within this whole dietary guidelines booklet. So we don't
13 want to have anything that comes across that this is
14 different guidance in terms of fat intake, or the whole
15 grains or fruits and vegetables, that it should be
16 compatible, that we're giving consistent advice, and I think
17 there are data to support the appropriateness of that
18 general recommendation.

19 Also including information of portion control,
20 considering possibly, however, moving specific focus and
21 emphasis, removing specific focus and emphasis on the
22 importance of fat restriction per se. That received a fair
23 amount of attention in the 1995 guideline. There are some
24 data that suggests that that may be not only an unwarranted
25 focus, but that it may actually be somewhat misleading, so
26 we have to restructure the wording or simply put the
27 emphasis on what we need to be doing in terms of building a
28 strong dietary foundation which includes good health and
29 weight control rather than specifically providing advice to

1 simply remove fat from the diet, restrict fat.

2 Finally in this regard, increase physical
3 activity, especially recognizing its role in weight loss
4 maintenance, and we'd like to greatly emphasize that, and I
5 think this will be done in two ways.

6 One, by enforcing it in the context of this
7 guideline; and, two, have a separate guideline which will
8 then cross reference and reenforce.

9 Finally, under special considerations, we've
10 talked about the importance of weight control in children
11 and older adults. This is probably not going to be a major
12 change or divergence from the 1995 guidelines, but with kids
13 we'd like to reenforce the message regarding the importance
14 of prevention of obesity beginning in childhood by way of
15 improving eating patterns compatible with the guidelines as
16 a whole, increasing time spent in physical activity, and
17 decreasing time spend in sedentary activities, such as
18 watching television.

19 Somewhat similar to the 1995 guidelines regarding
20 older adults, the recommendation that guidance of a health
21 care provider may be appropriate with regard to overweight
22 or obese older adults, giving special consideration to the
23 role of physical activity in this older population to
24 maintain muscle mass, strength, reduce risk of falls and
25 fractures, as well as reducing risk of co-morbid conditions
26 of the obese person.

27 Finally, under special considerations, one of the
28 members of the committee raised a question: Should we
29 further consider describing this guideline, the potential

1 role of drug therapy, anarchic agents, for example? And
2 concern was expressed by some members of the subcommittee
3 that this may be too prescriptive, perhaps too clinically
4 oriented for the dietary guidelines and for the general
5 readership of this guideline, but we will certainly consider
6 that in further deliberations.

7 So, Rachel or Shirika, did I miss anything or say
8 something that you think --

9 DR. JOHNSON: I would just like to -- I know I've
10 said this before. I would just like to emphasize that I
11 think some kind of graphic or box about portion size is
12 really critical. And as I look at the booklet, I think
13 there is a lot of misperceptions in the pyramid, for
14 example, in the grain group when it says six to 11 servings,
15 and when you look at this you know a serving is one slice of
16 bread, a half a cup of rice. And I think if you look at
17 current consumption patterns, that's not typically, if you
18 consider the amount that you have on your plate for meal,
19 that would be less than we might consider a serving.

20 So I just think if we can link the serving sizes
21 that are given with the pyramid in with the "achieve a
22 healthy weight," really stressing portion size and what is
23 considered a portion size when you flip back to this. I
24 think that would be useful.

25 DR. WEINSIER: Shirika.

26 DR. KUMANYIKA: What I would add is more advice on
27 eating behavior. As I look through the booklet there really
28 is a lot of -- the subhead anyway -- about weight, and there
29 is one about calorie intake, but I'm thinking about, you

1 know, how to tell if you're overeating. You can't measure
2 your energy balance, but you can get some clues to
3 overeating, and I don't know if the literature will support
4 any tips for people, but portion size and meal pattern or
5 snacking behaviors that might tell people that they're
6 actually eating more than they intend to or want to as the
7 behavioral bridge between the recommendations and actually
8 being able to do something about it.

9 DR. JOHNSON: I did fax Roland, I know, a few
10 weeks ago some behavioral weight control tips that are
11 commonly used in behavior weight control programs. And I
12 think the literature supports that behavior weight control
13 as along with physical activity is effective for weight
14 loss. Weight recidivism is another issue. But I think we
15 could pull that in, and I think we could pull some of the
16 pediatric things in there very nicely when we talk about
17 helping children to recognize internal cues of hunger, which
18 is kind of, I think, what you're thinking about when you're
19 talking about how do you know when you're overeating. So I
20 have some things on that that I think I shared with you,
21 Roland, and I can get to you, Carol, as well.

22 CHAIRMAN GARZA: Any other comments or questions?
23 Scott.

24 DR. GRUNDY: Yes. I think the waist circumference
25 is very important to put in. You know, that was developed
26 in the NHLBI and our DDK guidelines, but I think that really
27 it's time as come, and it might be a significant addition to
28 this guideline if we emphasize that. You know, it has
29 several advantages. It's metabolically more linked to risk

1 factors than total body weight, and it might get a little
2 bit around the problem of whether a BMI of 25 in some people
3 is overweight or not, because if you can add in the waist
4 circumference, you can find out whether there is a problem.
5 So maybe adding this on as a major new contribution of this
6 group would be very good.

7 I think that slide you showed where you tried to
8 combine the two together was a little problematic. You
9 know, we might talk about that. The way circumference is
10 most telling in people who are in the overweight range
11 rather than the obesity range is trying to say that they're
12 above a level of about 30, I think we've learned that, you
13 know, the waist circumference is not much of a factor then,
14 you know, than obesity as a whole take over. But certainly
15 in that range it's extremely important, in the moderate
16 range, and I would advocate that you really push that idea.

17 CHAIRMAN GARZA: Meir?

18 DR. JOHNSON: I wanted to add one thing about
19 pediatrics. I'm sorry. I know there are BMI charts for
20 children, and I've seen some things that have been included
21 in the team nutrition materials for USDA. And I think if
22 we're going to do a BMI thing, if we have room, it might be
23 nice to include some things for children as well.

24 CHAIRMAN GARZA: Meir? Johanna?

25 DR. DWYER: The BMI simply has to be different for
26 children. It's wrong to have adult BMIs.

27 DR. JOHNSON: Right. That's why I'm saying there
28 is a new chart that's based on the soon to be hopefully
29 released growth charts for children. They are a little hung

1 up, but they are due out soon and they've created some BMI
2 charts.

3 CHAIRMAN GARZA: Meir.

4 DR. STAMPFER: I was just going to talk about the
5 other end of the age spectrum, the elderly, where BMI is
6 actually not a very good predictor of adverse health outcome
7 compared to middle aged and younger old people, and I think
8 part of the reason is -- getting back to what Scott wa
9 saying -- there is a loss of lean body mass and you can have
10 the same BMI but be fatter in old age, and the waist can
11 pick that up.

12 CHAIRMAN GARZA: Shirika.

13 DR. KUMANYIKA: I'm just wondering if, without
14 setting a precedent that goes through all the guidelines, we
15 should have some sort of special issues box in the weight
16 group, because the Asian descent populations don't have
17 average BMIs that get to 25, that have very high risks
18 associated with waist circumference. If you don't say
19 anything about it might not pick that up, and it's -- so I
20 think it's important to have a place to mention that, and
21 that would also be a place to mention older adults and
22 perhaps some other groups for whom there are special weight
23 considerations.

24 CHAIRMAN GARZA: Given this sort of discussion,
25 how practical is it going to be -- again, I'm trying to
26 think of how lengthy this is going to get if we try to make
27 prescriptions for all age groups and physiological states.
28 To think about limiting perhaps some of the charts, then
29 giving -- referring people to other sources, so that rather

1 than putting in a chart that could be misleading because
2 either of ethic issues or age issues, to say, you know, if
3 you're interested in losing weight and want to check whether
4 your weight is adequate, then go to this other resource,
5 because if we try to put it all in one book, then what age
6 group are you going to use. And I'm not saying that that's
7 the way we have to go, but we may want to give Carol enough
8 leeway to say, well, if it can be done, obviously the ideal
9 is to put everything in one text.

10 If it can't be done, how would you prefer erring?
11 Leaving out a specific age group, and therefore should we
12 make young adults the focus and refer everybody else to
13 other sources, or just refer everybody to other sources?
14 Let me ask Roland as the chair to address that.

15 DR. WEINSIER: No, I'm very comfortable with that.
16 I like that idea as long as there are precedents for this
17 and we're not getting into issues about it's inappropriate
18 to be referring to other documents that perhaps are not
19 either produced by the government or if they are specific,
20 you know, non-federal documents. Are there any technical
21 issues related to that?

22 I'm not uncomfortable with the general concept.

23 CHAIRMAN GARZA: No, I think that it's --
24 obviously we can go to a surgeon general's report to or an
25 NIH document, that those would be the preferable ones
26 because of the process that most of those documents are put
27 through.

28 If we went to a specific commercial source for
29 advice, then I think we'd have some problems if we were

1 recommending a specific weight control program, for example,
2 as the origin for information.

3 DR. LICHTENSTEIN: I would just like to urge that
4 we've said numerous times that prevention is our key target
5 here because treatment has a pretty dismal failure rate. So
6 I think if we're going to emphasize prevention, we have to
7 say something about the pediatric population.

8 CHAIRMAN GARZA: No, no, I'm not --

9 DR. LICHTENSTEIN: Yeah.

10 CHAIRMAN GARZA: -- saying that we don't mention
11 them, but that, in fact, if we're going to focus on
12 prevention to do that, but if people are concerned about
13 their weight and want to look at weight loss or other
14 things, to send them then to other sources for treatment as
15 a way of trying to contain the size. So I mean, it's just
16 a suggestion.

17 DR. JOHNSON: I think it would be nice if we had
18 at least something to help people recognize whether -- I
19 mean they say --

20 CHAIRMAN GARZA: So what age group would you --

21 DR. JOHNSON: -- look in the mirror. I mean,
22 that's probably the best test, but --

23 CHAIRMAN GARZA: What age group then would you ask
24 we prioritized? I think trying to get them all in might be
25 difficult but, you know.

26 DR. JOHNSON: Well, I think children needs to be
27 in there.

28 CHAIRMAN GARZA: Well, some of us think children
29 are the point, the rest of us are lost causes.

1 Scott?

2 DR. WEINSIER: I'd rather look for -- oh excuse
3 me. I'd rather look for some generic type recommendations
4 that are applicable through the -- you know, over two age
5 population, and there may be some caveats that would be
6 specific for, you know, younger and older groups. But to
7 try to, for the sake of this document, which is for the
8 general population, I mean, I suspect there are probably
9 some general -- if we phrase it correctly, that we could,
10 you know, hit some major points that would be applicable
11 throughout the age, and a number of subgroup spectrums.

12 CHAIRMAN GARZA: All right. So then Carol's
13 guidance is prioritized the generic statements, give them
14 the most importance, and then look at, if we add charts for
15 all age groups, what that does to lengthen, and then we can
16 decide at a later point whether we're going to eliminate
17 them or not.

18 Okay, Johanna, you had your hand up?

19 DR. DWYER: I remember Shirika said something
20 yesterday, if you do one, then you have to do them all. And
21 I don't know how to deal with it, but I think one way is to
22 certainly reference other sources like you would on an
23 internet web site, and prioritized the generic ones, and
24 then we can decide. I don't want to try to write a book in
25 our heads today.

26 CHAIRMAN GARZA: No, we can't.

27 DR. DWYER: We still haven't decided what the
28 major things are.

29 CHAIRMAN GARZA: Now, on guidelines -- I'm

1 sorry -- on physical activity, please either, you know, if
2 you're not prepared today to suggest who we might want to
3 add as consultants to this group, then send your
4 recommendations or suggestions to either Shanthy or to me
5 because we need to get those individuals working with this
6 group as soon as we can if we're going to evolving a
7 guideline.

8 I didn't hear anyone objecting in the comments to
9 at least drafting something separate for a physical activity
10 guideline, that we would then take up at our next meeting as
11 an option.

12 DR. DWYER: I would like to see an expert on
13 physical activity who recognizes the importance of diet as
14 well. Sometimes the physical activity people go off on
15 their own tangents, and we're a Dietary Guidelines
16 Committee, and I think what we're talking about is be
17 holistic and inclusive, but it really does have to relate
18 back to what people eat.

19 CHAIRMAN GARZA: Okay. Scott, then Suzanne.

20 DR. GRUNDY: You said something about this
21 prevention versus treatment idea. It seems to be kind of a
22 dichotomy. I think, from my view, obesity is a risk factor.
23 It's not a disease, but it's a risk factor for future
24 disease. So the whole idea is prevention. So you're
25 preventing excess weight gain once. If you got weight gain,
26 you're preventing further weight gain. You're preventing
27 the consequences of obesity, so it all is prevention, and
28 somehow it shouldn't be built in that we're just trying to
29 prevent obesity, because even after you're overweight, there

1 is varying degrees of overweight, so it's a continuum and
2 the risk is a continuum, so the concept of prevention should
3 be in there throughout.

4 CHAIRMAN GARZA: That's a good point, yeah.
5 Okay, Suzanne.

6 DR. MURPHY: I guess I want to be sure that
7 somewhere as the guideline is worded we keep in mind the
8 real back lash in America against the government, and, I'm
9 sorry, we will be seen somewhat as the government, telling
10 Americans they are all too fat and they're all unhealthy,
11 and a disconnect with the guidance that's coming from us all
12 about obesity. Let's be sure we're not to use the term used
13 before, overly prescriptive in saying what is healthy and
14 what is unhealthy.

15 I know we have very good scientific evidence on
16 the risk factor that is obesity, but if the tone of the
17 guideline can at least recognize the frustration being faced
18 by a huge number of Americans who has suddenly with the new
19 guidelines found out they were fat and never knew they were
20 fat before. Let's not further perpetuate the problems that
21 have been caused by some of the changing definitions would
22 just be my plea.

23 CHAIRMAN GARZA: The goal will be then to tell
24 Americans the truth but not make them feel terribly guilty.
25 Okay.

26 DR. STAMPFER: Share the pain.

27 CHAIRMAN GARZA: Share the plain, that's right.

28 All right, then, before taking on the next
29 guideline let's take a break and try to be back in 10

1 minutes so that we can all make -- Kathryn?

2 MS. MCMURRY: During the break I'll be passing
3 around a list, a lunch order list, if you could please fill
4 it out, we'll get it.

5 CHAIRMAN GARZA: Now, I'm sorry. Before the group
6 breaks up, one minute, we need to get -- I still have hopes
7 that we can get some focus groups, although they are not
8 great, the hope I mean, but we will continue to hope. So
9 that if there are specific items that you want tested, and I
10 forgot to ask the variety folks to think about that, and
11 then if the weight or physical activity, there are things we
12 need, then I'd like to get a list to Carole over today, and
13 maybe we want to add to that list before the end of the
14 week, to Carole Davis, so we can give them some specific
15 things to prioritized on, that we would like to have
16 information on as soon as we can.

17 Okay.

18 (Whereupon, a recess was taken.)

19 CHAIRMAN GARZA: Will each of you -- If we'll take
20 our seats, we'll move on then to the third working group,
21 and I don't know whether Dr. Deckelbaum will be doing this
22 from the podium or from his place. He's there, good. So
23 it's choose a diet with plenty of grain products, vegetables
24 and fruit working group.

25 DR. DECKELBAUM: Just getting my audio visuals
26 ready here.

27 Well, this is -- this is essentially what I showed
28 yesterday in terms of the different options that our working
29 group had considered prior to coming here. And then in our

1 later discussions, I'd just like to inform you of where
2 we've come in terms of considerations for the next edition
3 of the guidelines. And it's not necessarily in the same
4 order, but they're interrelated strongly. And basically
5 everything that's on the "options reviewed" has come out
6 with some more focused considerations that we plan to pursue
7 and bring up to the entire committee.

8 So let's go to the bottom of this overhead which
9 would be "A clearer implementation guidance for grain,
10 vegetables and fruits." And we believe that we should have
11 very serious consideration now for separating grains from
12 fruits and vegetables in a separate guideline group, so
13 there would be a grain group and there would be a fruits and
14 vegetable group.

15 The rationale for this consideration is based both
16 on the science and evidence that's accumulated in the last
17 five years, plus we believe that it will make great strides
18 towards more efficient and wider implementation of healthier
19 guidelines.

20 So in terms of the science, I think that in the
21 last five years, as I showed yesterday, there has been a
22 clear proliferation of a number of good studies showing or
23 increasing the concept that whole grains have health
24 benefits and are able to reduce risk of more than one
25 chronic disease group, and we referred to specifically
26 cancer, heart disease and to insulin resistance-related
27 diabetes, so that the data is coming there. It was there
28 before to some extent, but it's been markedly strengthened
29 in the last five-year period. So from the science base it

1 makes sense.

2 As well, the science base is showing that the
3 benefits of grains, whole grains in particular, are
4 distinct, although they may be related, to benefits of
5 dietary fiber. So that there are -- when you do adjustments
6 for fiber versus -- in whole grain you can see that the
7 benefits of whole grain are not, certainly not totally
8 dependent on fiber intake and there are independent benefits
9 likely -- not likely that are associated with whole grain
10 intake that justify its standing up there on its own; grain
11 standing up there on their own.

12 As well, we think that because plant foods in a
13 way should form the basis of the diet, it makes sense to
14 have them in two separate groups so that you can better
15 emphasize each group without trying to give -- you know, mix
16 them together.

17 And this brings us to the top line here, which was
18 an increased emphasis on whole grains in the guideline
19 itself and in the text. So if you look at Box 9 -- this is
20 the one I had a slide of yesterday -- over here, so this --
21 I know it's difficult for some of you to read the exact
22 wording. But of the -- of the 11 points here, three of them
23 relate to grains, and -- so therefore we think that the
24 message on grains will get across better if it had its own
25 box, and you could amplify.

26 Now, the concept of whole grains being important
27 is not entirely new because in this box these top three
28 bullet points refer to grains, and two of the three bullet
29 points actually refer to whole grain intake, so it's not

1 new. It's there. And what we'd like to do is enhance it by
2 putting it in a guideline itself and emphasizing it further
3 in the text.

4 But I think an important point in our
5 considerations is that conclusion of whole grains does not
6 necessarily mean exclusion of other grains, and in coming to
7 what our final sort of recommendations are going to be,
8 we're asking for more analysis to be given to us on the
9 potential of increased whole grain intake, diminishing
10 intake of other potential nutrients that could be contained
11 in enriched or fortified foods. So we think this is an
12 important point that we need data on. Our early review of
13 this did not seem to show any disadvantage, at least in
14 terms of foliate, but there is other micro nutrients that we
15 have to examine, and we'll be working on this over the next
16 few weeks to try to get balances of what happens if all this
17 happens versus another situation, different kinds of
18 potential scenarios.

19 Now, one that we handled relatively easily was the
20 increased emphasis on nut ingestion, and we believe this
21 should be better emphasized in the new general guidelines,
22 but we've taken care of it very easily by passing it on to
23 another group, and among discussions, we thought that it
24 might fit better under the fat guidelines, but this is still
25 to be determined.

26 And, finally, we've discussed the clear definition
27 of different types of carbohydrates, and more emphasis on
28 quality versus quantity of grains and of fruits and
29 vegetables; I guess in separate categories now. So that we

1 do agree that, with the recent scientific evidence, that
2 there is justification for emphasizing certain kinds of
3 carbohydrates and the foods that contain them in terms of
4 priority relative to other kinds of carbohydrates and that's
5 foods that are less -- less micro nutrient and macro
6 nutrient enriched, and that compared to foods that might
7 contain -- well, basically what I'm trying to say is empty
8 calories versus enriched food sources which provide more
9 than calories and other kind of health benefits at the same
10 time.

11 And I think that basically sums up the discussions
12 that we had yesterday and where we plan to go.

13 CHAIRMAN GARZA: Okay. Are there other comments
14 from other members of the group?

15 DR. WEINSIER: This is probably a question to
16 Carol. When we talk about whole grains, I bet if we went
17 around the table we'd probably have a pretty good feel for
18 what we're talking about, but I don't know what the
19 consumer's perception is of whole grain, what meaning it
20 has. And it doesn't need to be answered now; it's just a
21 matter of is this a consumer focus group, user friendly
22 term.

23 CHAIRMAN GARZA: I would add that to the list.
24 Remember I asked that right at the break that we start
25 thinking about specific issues we'd like some information on
26 in terms of consumer perceptions. So whole grains would be
27 one.

28 Alice and then Shirika.

29 DR. LICHTENSTEIN: Along those same lines now, the

1 nuts going from one group to another, but still I'd be
2 interested in getting some information on exactly what the
3 pattern is on nut consumption, whether -- you know, what
4 proportion is coming from candy bars versus other kinds of
5 things, so that we might be able to target the
6 recommendations.

7 CHAIRMAN GARZA: Okay. So Shanthy, that would be,
8 you heard the -- okay.

9 Shirika, did you have something?

10 DR. KUMANYIKA: Just because sometimes when
11 something is recommended people go overboard with it. Are
12 there any cautions needed in the nut recommendations related
13 to children or the allergenic properties?

14 CHAIRMAN GARZA: I'm concerned about the allergy
15 issue, and that's something we need to think about more
16 carefully, especially with peanuts.

17 Suzanne?

18 DR. MURPHY: And also along the nut line, I'd be
19 interested in what consumers will say if we call it a fat
20 because I think that gives nuts a very negative image. And
21 since I like it -- yeah, yeah, just another issue to be
22 investigated a little bit more.

23 CHAIRMAN GARZA: Okay. Then we'll -- Johanna, are
24 we ready to move on to the next --

25 DR. DWYER: Well, I think we have to mention a
26 whole bunch of different foods. If we mention nuts and we
27 don't mention anything else, milk, legumes, all the others,
28 I think that would be unbalanced, but I'm sure we can do it
29 in an even-handed way.

1 CHAIRMAN GARZA: Okay. Richard?

2 DR. DECKELBAUM: Thinking about nuts, we've got
3 also concerns of the children. Once again, you know, it's a
4 major -- it's a major cause of aspiration and even death in
5 young kids, so that's got to be built in that, you know,
6 kids probably should be allowed to get it. There is the
7 allergy component, but the major message, I think, should be
8 somewhere and maybe it isn't, because it's really a positive
9 message that there are health benefits that are associated
10 with nuts. And, you know, we had some discussion yesterday
11 about the "do" guidelines versus the nut guidelines, and if
12 we want to increase nuts as part of health, it should be
13 more in the positive "do" guideline.

14 CHAIRMAN GARZA: Okay, we'll take one last
15 question on this. Looking at the clock, that's the end.

16 DR. LICHTENSTEIN: I guess I'm still not convinced
17 that nuts per se are good just as a stand-alone. I think
18 that the fatty acid patterns associated with the fat in nuts
19 may be compatible with we're currently recommending, but
20 singling out one food and saying, "Well, this food is good
21 as this. This food is associated with health benefits," as
22 opposed to saying, "Well, dietary patterns that include this
23 whole variety of foods are associated with better health
24 outcomes," this seems more reasonable to me at this point.

25 I'd also be interested focus group-wise as to what
26 the perception would be if a message saying "increase nut
27 intake." Does that mean that if I sprinkle walnuts over my
28 hot fudge sundae, it's going to negate all the saturated fat
29 that's in the whipped cream.

1 CHAIRMAN GARZA: It makes it taste much better.

2 (Laughter.)

3 DR. LICHTENSTEIN: But really, how is it going to
4 be perceived by the consumer.

5 CHAIRMAN GARZA: All right, then, let's -- and I'm
6 assuming that the group is going to work on both a grain and
7 a food and vegetable --

8 DR. DECKELBAUM: We may bring you in --

9 CHAIRMAN GARZA: guidelines?

10 DR. DECKELBAUM: -- as well, so we can have two
11 and two.

12 CHAIRMAN GARZA: Okay. All right, then, let's
13 move on then to choose a diet low in fat, saturated fat and
14 cholesterol.

15 Dr. Grundy.

16 DR. GRUNDY: If you don't mind, I'll sit here --

17 CHAIRMAN GARZA: No, you can do that.

18 DR. GRUNDY: -- because I think we can dispose of
19 this pretty soon, I hope.

20 Well, the current recommendation if we look at the
21 overriding recommendation is to chose a diet low in fat,
22 saturated fat and cholesterol. And our group proposed that
23 the rank ordering or the priority be changed in this list to
24 read -- the overriding recommendation would be "choose a
25 diet low in saturated fat, cholesterol and fat," so that the
26 emphasis will shift more to saturated fat and away from
27 total fat.

28 And the reason for that is that we think the
29 scientific evidence is strongest for the link between

1 saturated fat, cholesterol, coronary heart disease, and it
2 could be estimated that about 25 - 30 percent of coronary
3 heart disease could be attributed to the high intake of
4 saturated fat and cholesterol, and there is a lot of strong
5 scientific support for that.

6 The low in total fat is a little bit more
7 contentious, and that's why we wanted to move it down on the
8 priority list. This has a long history, the concept of low
9 fat diets, goes back for many years. There is a lot of
10 belief systems built in around that. Some people believe
11 that low fat diets reduce the risk for heart disease
12 independently of saturated fat. Other people believe that
13 diets in a low percentage of fat reduce the risk for
14 obesity, and others believe that it reduces the risk for
15 cancer.

16 So there are lines of evidence to support all
17 those beliefs. A lot of it is epidemiologic, some of it's
18 studies in animals, not enough clinical trial evidence. But
19 there is a body of data to reenforce that view.

20 We also feel that strengthen those data are not
21 nearly as strong as they are for the saturated fat, blood
22 LDL cholesterol link, and, in fact, I think if there has
23 been a change in that view, it's towards less of a
24 connection. We heard a talk yesterday about the connection
25 between dietary fat and cancer, and it seems like it's not
26 as strong as it was previously if you look at the
27 observational studies and epidemiologic studies that are out
28 there.

29 So I think it's also being questioned whether a

1 low percentage of fat in the diet actually will prevent
2 obesity. We've had a low fat guideline for a long time and
3 yet obesity is increasing, percentage of fat actually has
4 gone down, although not absolute amounts, but absolute
5 amount of carbohydrate intake, we think, may have gone up,
6 so to some extent our message may have backfired on us.
7 So I think we want to soft pedal the low fat a little bit
8 compared to what we used to, and integrate it more into a
9 general comment on total caloric intake.

10 So that's sort of the basis for our shift in
11 emphasis. In addition, we may leave some of the language as
12 we recommended before pretty much the same. As we discuss
13 each topic, we want to make a strong care for the scientific
14 base of saturated fat. We want to review the evidence for
15 cholesterol and reenforce that. There's an ongoing question
16 about the importance of dietary cholesterol. We have to be
17 objective and careful. I think I tried to present the case
18 yesterday why we believe that it should be in the guidelines
19 and not eliminated.

20 And then we had come up with some language
21 suggesting that the low fat be closely linked more towards
22 low total fat in absolute terms than percentage fat; shift
23 the emphasis there somewhat in the direction of integrating
24 it in with a total nutrient, macro nutrient intake.

25 So I think that represents a view of our
26 committee. I don't know that it's a total view of everyone
27 in the room, but it's where we came down after further
28 discussion after yesterday's meeting.

29 CHAIRMAN GARZA: Okay. Any comments, Richard?

1 DR. DECKELBAUM: I would just like to add that we
2 did discuss children, and within the group we felt that the
3 recent evidence from the DISK study, the CAP study and the
4 STRIP study in Finland, that we recommended amounts of fat,
5 10 percent saturated and 30 percent total, are safe for
6 children; and that we thought that this could be implemented
7 or try to reach that goal beginning with the age of two.

8 DR. GRUNDY: Yeah, that reminds me. Another
9 reason I think is that for, you know, keeping the language
10 the same, although we changed around a little bit, and its
11 priority was we're really not coming down with a different
12 recommendation in quantitative terms. I don't know whether
13 that's our goal to do that, but there were quantitative
14 numbers put on the last time, and we're going to try to keep
15 those pretty much the same.

16 CHAIRMAN GARZA: Scott, at the risk of initiating
17 a long debate, but I'll try to gavel it if the risk proves
18 to be real, I've heard the working group's concern about
19 trying to really focus the public's attention on saturated
20 fat.

21 Would we achieve that goal if we chose as a pithy
22 statement "Choose a diet very low in saturated fat and
23 cholesterol and low in fat"? Or would that -- is so subtle
24 that people would never catch it, be confusing in trying to
25 capture the concern that you have that we really need to get
26 people to focus more on the type of fat than the total
27 amount of fat?

28 And then we'll take this up for about five minutes
29 and then we'll move on to the next one.

1 DR. GRUNDY: Okay. Well, I think that that -- you
2 know, what you just said would square with what we believe.
3 Whether, you know, that's too -- you know, a little bit
4 radical, any time you use the word "very low" in there, you
5 know, it implies some kind of a radical change, I think, so
6 I think we have to be a little bit careful about that, and I
7 guess that would be my only concern although that's
8 certainly -- we want to go in that direction.

9 Now, we thought changing the emphasis might take
10 us there. Our current intakes of saturated fat are around
11 11 - 12 percent, and we also believe that trans fat is at
12 least equivalent to saturated fat, so if there is another
13 two or three percent, that would leave us around 15 percent
14 of cholesterol-raising fat in the diet, which is a lot.
15 And, you know, I think a lot of us would like to see that
16 cut in half; get down around seven percent or something, and
17 I don't know whether that's very low or low. I'm not quite
18 sure.

19 CHAIRMAN GARZA: So we could decide if it is or
20 not.

21 DR. GRUNDY: But, you know, I guess -- I think
22 that a change in the emphasis already is going in a certain,
23 is going in that direction. I don't know whether adding
24 "very low" is a good idea or not.

25 CHAIRMAN GARZA: All right. Anyone -- Alice.

26 DR. LICHTENSTEIN: I would be a little bit
27 concerned with that approach although it's consistent with
28 the intent. I think by putting "very low in saturated fat"
29 would imply that we're changing the targets, and right now I

1 don't think it has come up that we want to change that 10
2 percent or less, at least for this guideline and this issue,
3 and especially given that the school lunch program and some
4 other programs are based on those numbers, so that might
5 lead to confusion.

6 CHAIRMAN GARZA: No, I mean, the numbers don't
7 change --

8 DR. LICHTENSTEIN: Right.

9 CHAIRMAN GARZA: -- I mean, based on what we've
10 said. It's just a matter -- I'm trying to deal with a
11 concern I heard the working group was wrestling with, and
12 some of us came down pretty hard when we were having that
13 discussion on total fat issues. I went home saying, well,
14 all right, how else could we achieve the same aim. But
15 Meir, and then we'll -- I don't know whether Suzanne would
16 like to say something.

17 DR. STAMPFER: Well, I don't think we have any
18 reasonable basis for restricting intake of polyunsaturated
19 and monounsaturated fats. In discussing this, the reasons
20 for maintaining that restriction, we've done it before, and
21 one committee member characterized it as the sins of the
22 father, that we've kind of stuck with this mantra that fat
23 is bad and that we can't dig ourselves out of the hole.
24 Well, I think that's against the spirit of every five year
25 review.

26 Another position was we should wait for the
27 Women's Health Initiative because as a component of that
28 trial there's a low fat part. The data for that will not
29 even be available for preparation of the 2005 guidelines let

1 alone this year's guidelines. We're always waiting for new
2 data, so don't regard that as good evidence.

3 One of the fears was cancer, and that's really
4 been allayed by emerging data. So we're left with the
5 weight gain, which is controversial, and I think some people
6 believe that fat is particularly causative for weight gain,
7 other people don't. My own take is that the evidence is not
8 that strong.

9 And you could say, well, what's the harm in
10 limiting mono and polyunsaturated. Well, I think there is
11 harm because we know that polyunsaturated fats are
12 beneficial, and this isn't projections or pie in the sky;
13 this is randomized trials with clinical outcomes that have
14 shown that if you substitute polyunsaturated fat for
15 saturated fat, you've reduced coronary heart disease and you
16 don't increase any other adverse health outcome. So I think
17 we should consider that.

18 CHAIRMAN GARZA: So, Meir, are you suggesting that
19 we go above 30 percent fat?

20 DR. STAMPFER: No, no. I don't think we should
21 make a --

22 CHAIRMAN GARZA: We're not changing the number --

23 DR. STAMPFER: No.

24 CHAIRMAN GARZA: -- is what I am hearing.

25 DR. STAMPFER: No, my suggestion -- my suggestion
26 is to drop the restriction on total fat, and just restrict
27 the fats that we consider harmful; namely, saturated fat,
28 cholesterol and trans.

29 CHAIRMAN GARZA: Well, maybe what we should do is

1 go to a focus group because the concern that I heard
2 expressed was by dropping total fat, that the public then
3 would interpret that to mean that we were going above 30
4 percent.

5 DR. STAMPFER: Well --

6 CHAIRMAN GARZA: And since the group isn't
7 recommending that we should fall below 30, that's still
8 consistent with a low fat diet as a way it's been defined.
9 So that we could always go to a focus group and says, "Now,
10 if we don't say that, is that permissive in going above 30?"

11 Now, if you're arguing for going above 30, we need
12 to be more explicit.

13 DR. STAMPFER: Can I just respond quickly?

14 CHAIRMAN GARZA: Yes.

15 DR. STAMPFER: I'm not arguing going above 30.
16 I'm arguing against any particular target. I think 30 is
17 reasonable, but I don't think we should say you're eating an
18 unhealthy diet if you go above 30. I think we shouldn't
19 have a prescriptive number except to say maybe the 30 is
20 reasonable, because I think what Suzanne pointed out really
21 quite on target; namely, that if we put nuts with fat, it
22 will have a bad imagine. Well, that's because we've
23 promoted this mantra of fat is bad, and I think we've got to
24 face the emerging data that suggests that certain kinds of
25 fats we need to be avoided, but certain kinds of fat are
26 actually essential for our well being.

27 CHAIRMAN GARZA: And you feel that is now
28 sufficiently accepted by the scientific community that no
29 one will argue with Dr. Stampfer's view --

1 DR. STAMPFER: No one will argue? Of course,
2 everybody is going to argue. That's why I'm arguing.

3 (Laughter.)

4 CHAIRMAN GARZA: And what I'm saying is that
5 it's -- one of the hardest things for committees to do is to
6 understand that we're not here to -- the end result very
7 seldom is personally satisfying, and that's why I was
8 pushing. It has to -- it has to reflect what we think is
9 the best consensus of the nation's scientists. Now, if you
10 feel very strongly that in fact we need to reforge a new
11 consensus, then we need to be explicit in that, or there is
12 data that is pushing us in that direction to be more
13 explicit. But I need to have a sense from you as to whether
14 or not the views you've just expressed are pretty common.
15 Now, I mean, in fact --

16 DR. STAMPFER: One quick thing and then I'll shut
17 up.

18 CHAIRMAN GARZA: Yeah.

19 DR. STAMPFER: I think our recommendations have to
20 be based on evidence.

21 CHAIRMAN GARZA: That's right.

22 DR. STAMPFER: And if -- I'm awaiting to hear some
23 credible evidence that's strong enough to support a
24 limitation of polyunsaturated fats and monos given the
25 proven benefits of polies in randomized clinical trials.

26 CHAIRMAN GARZA: Okay.

27 DR. JOHNSON: I would just like to reinforce what
28 we had talked about yesterday, which is bringing in an
29 expert at our next meeting on the role of fat and obesity,

1 and I've drafted a list of names because I think there is
2 still some issues about the metabolic efficiency of the
3 different macro nutrients, and there are some metabolic
4 clinical data that could support that. So I'd like to hear
5 from someone about those.

6 CHAIRMAN GARZA: Okay, Roland and then Shirika.

7 DR. WEINSIER: Yeah, I think I understand what
8 Meir is trying to say, but the way I'm looking at it if wise
9 men disagree, then there is probably more information we
10 need to resolve this issue. I mean, we had a --

11 CHAIRMAN GARZA: Include wise women now as well.
12 We'll get into trouble.

13 DR. WEINSIER: Yeah, wise individuals. I mean, we
14 had a very hot and interesting debate that was, you know,
15 presented in the New England Journal, I thin, a year or so
16 ago in terms of what foods to substitute. It's clear, as
17 Meir is saying, we don't have the answer in terms of what's
18 the idea diet for weight control.

19 I'm just not convinced that the data in to allow
20 us -- see, I'm looking at reverse direction. It's not just
21 a matter of restricting fat, it's the reverse, and that is
22 that we're not recommending a higher carbohydrate intake, or
23 if we don't restrict the fat, then we're recommending a
24 lower carbohydrate intake. There are only so many calories,
25 and those are the two calorie providing groups.

26 So I think we have to keep that in mind in terms
27 of the major illness in this country, one of which is weight
28 control. The answer is really not in, in my opinion, and
29 that means that we have got to be sensitive to this.

1 CHAIRMAN GARZA: Shirika.

2 DR. KUMANYIKA: Two unrelated comments. One has
3 to do with the wording. In the spirit of compromise wording
4 where you said "choose a moderate fat diet that's low in
5 saturated fat and cholesterol," would that help to get
6 around the problem of targeting the fat intake?

7 Just to consider as we go forward trying to do
8 that, that we get "low" and "fat" disassociated from each
9 other, and put "moderate" in there.

10 The other comment is I'm not sure I agree with
11 Rachel about getting in people to talk about metabolic
12 differences in fat, and this is having been a part of the
13 NHLBI guidelines where we tried to look at -- on obesity
14 treatment we tried to look at the behavioral effects of fat,
15 not the metabolic effects.

16 In other words, when people were in studies where
17 they lowered their fat, was that more conducive to weight
18 loss? Not necessarily for metabolic reasons, but because it
19 was easy for them to find the foods that they wanted. And
20 so I think if we look at the metabolism but we don't look at
21 how these things play out in the whole person, the lifestyle
22 situation, we might end up with the wrong conclusion, and so
23 that's -- we may need experts to talk about the role of fat
24 in weight management, but it may not be from a metabolic
25 point of view.

26 CHAIRMAN GARZA: Okay. Johanna?

27 DR. DWYER: I fully endorse the revision in terms
28 of the saturated fat, the cholesterol, and I'm the person
29 who feels very strongly that the consensus is not reached

1 about total fat, and that this would not reflect the current
2 view of the science.

3 But the bigger problem is that I think we may need
4 to give more attention to foods and diets rather than
5 focusing on single nutrients, and that it will be
6 impossible, I don't know, maybe the consumers can tell you
7 in a focus group what they mean by "low," but I think it may
8 be a mis -- you're listening from cardiovascular ears to
9 what low and high are, and it's not at all the same as what
10 the average consumer things. So I think we need to focus on
11 foods and actionable advice to the extent that this is a
12 consumer document and clear advice to policymakers for the
13 part of this document that really is not for consumers but
14 rather for government and voluntary and other organizations.

15 CHAIRMAN GARZA: I think we've had enough -- well,
16 we've had a number of suggestions, Carol, for the focus
17 group on fat, and you've gotten them all down.

18 DR. SUITOR: I hope.

19 CHAIRMAN GARZA: Well, then, perhaps you could
20 then e-mail to the group and then we'll add or subtract to
21 them.

22 Roland.

23 DR. WEINSIER: Just very quickly another consumer
24 issue. Is the word "saturated" readily understood? I mean,
25 it's in -- when you look at a package of food and you look
26 at the content, the word "saturated" is there. So if we
27 were to say, you know, "Choose a diet low in saturated fat,"
28 if this wasn't looked at last time, and I have to guess it
29 was, are we clear that people understand and are going to

1 choose a food that's --

2 CHAIRMAN GARZA: Well, let's go to Dr. Gieger and
3 see they -- was that term tested at all when you looked at
4 your focus groups?

5 DR. GIEGER: We didn't look specifically at
6 saturated fats. Some of the people who had relatives or
7 friends of coronary heart disease knew saturated fat was
8 something they needed to eliminate, but they certainly
9 couldn't define it. And others just thought fat was fat.
10 and cholesterol, they really call it fat.

11 CHAIRMAN GARZA: I've had students in organic
12 chemistry classes that don't understand the term
13 "saturated," so it's not surprising.

14 All right, then Scott?

15 DR. GRUNDY: You know, one other thing that I
16 think is important is how are we going to get at this
17 problem of the low fat food, proliferation of very low or
18 fat free foods that are high in calories that are, you know,
19 out there in the market and to some extent were in response
20 to our low fat recommendation? Are guidelines going to deal
21 with that in any way that will help to reduce that?

22 Now, the moderate in sugars, I think, is one step
23 in that direction although that was not the primary purpose
24 of that. But is there anything that we can say and include
25 that will get across the concept that there are bad fats and
26 bad carbohydrates both?

27 CHAIRMAN GARZA: We talked and different groups
28 have talked about trying to incorporate some of that
29 language in the weight maintenance category, perhaps in the

1 introduction, whatever way we decide to try to unify
2 everything to make people aware of the fact that just
3 because it is low fat doesn't mean that it doesn't have
4 calories.

5 DR. JOHNSON: One suggestion might be even a
6 comparison of labels which is something I do all the time.
7 When you compare a regular food product with the low fat
8 version, often there is very small difference in calories,
9 and even by circling that and highlighting that, maybe it
10 would be a way of pointing out that just because it's low
11 fat it isn't necessarily low calorie.

12 CHAIRMAN GARZA: The other thing we might want to
13 do is consider asking the secretaries, I think the common
14 phrase is that they focus some attention on current
15 labeling. I mean, we think that the labeling is misleading
16 because by saying "low fat" the implicit understanding of
17 consumers is that it's low calorie, that perhaps we ought to
18 ask them to reinvestigate that to make sure that consumers
19 are not misinterpreting it as easily as perhaps they are.
20 So there are various ways we can go beyond the guidelines in
21 terms of getting the secretaries to look at issues.

22 The last comment now.

23 DR. LICHTENSTEIN: Just one other thing to
24 consider in line with that is a lot of those foods that are
25 now labeled low fat, maybe some are calorie-wise, the fat
26 that was taken out was unsaturated and not saturated, so we
27 miss the mark on what we really intended to do.

28 CHAIRMAN GARZA: Okay. Rachel. Moving on then to
29 choose a diet moderate in sugar is the current guideline.

1 (Pause.)

2 DR. JOHNSON: Maybe. I will just have to use my
3 notes.

4 Okay, we had talked about the sugar guidelines,
5 and what I wanted to present was a potential outline. You
6 know, my notes are all on my slide so I'm going to have to
7 at least pull that up so I can do it. So why don't we move
8 ahead and I'll just --

9 CHAIRMAN GARZA: Well, why don't we go to the next
10 one and --

11 DR. JOHNSON: -- do it from my desk.

12 CHAIRMAN GARZA: From your computer, and that's
13 with the computer. Okay, that would be fine.

14 Then, Shirika, can you move on --

15 DR. KUMANYIKA: Yeah,

16 CHAIRMAN GARZA: -- and then we'll come back to.
17 Do sodium and then we'll come back and do sugars.

18 DR. KUMANYIKA: I decided to go low tech and to
19 write --

20 CHAIRMAN GARZA: Shirika, can you get the
21 microphone on, or it should be right there, the label?

22 (Pause.)

23 DR. KUMANYIKA: I tried to outline on these
24 transparencies the -- you pulled the plug on it -- what I
25 think are the key points that we need to go over and resolve
26 for salt and sodium. The first two pertain to the overall
27 guideline and consider changing the wording of the
28 guideline, so maybe we could -- should we discuss these now
29 or should I just go through and present --

1 CHAIRMAN GARZA: However you wish.

2 DR. KUMANYIKA: I think we -- so to retain the
3 guidelines, we agreed yesterday, but to consider the wording
4 and drop sodium, and the other one I was wondering as I went
5 through making the notes was whether -- yeah, we have that
6 word "choose a diet" in a lot of these guidelines and, you
7 know, what seemed to make sense five years ago may not make
8 sense this time. if we say "choose foods" for -- "choose
9 foods that are low in sodium," it would pick up the -- "or
10 low in salt," it would pick up the fact that a lot of the
11 salt is already in foods. But because there are seasonings
12 that people are substituting, you would miss that, so maybe
13 you do have to keep the "choose diet."

14 But does anyone have reactions to the idea of
15 trying to drop the word "sodium," or will we take that back
16 to focus groups?

17 CHAIRMAN GARZA: I don't think we would have to
18 decide right today, but we could certainly ask Carol to add
19 that to her list.

20 DR. KUMANYIKA: Okay. You're going to be busy.

21 I mean, sodium does have partly the medicinal
22 feeling, people -- patients will recognize low sodium diets,
23 but it may not be helpful in the bullet of the guideline if
24 it's mentioned someplace else in the definition.

25 What about the word "diet," should we add that,
26 the use of the term "diet," which sounds like "dieting,"
27 because it's in several of the guidelines now; should we add
28 that to the focus groups? Was that covered?

29 CHAIRMAN GARZA: That was -- I don't know whether

1 that was covered in the past, whether diet means a reduced
2 caloric.

3 Connie, has that --

4 AUDIENCE: (Not on microphone.)

5 CHAIRMAN GARZA: Choose an eating pattern.

6 DR. KUMANYIKA: I mean I avoid "diet". I can't
7 even use it in questionnaires because a lot of consumers
8 take "diet" to mean a prescribed diet, so I just mention
9 that in relation to the sodium.

10 Meir?

11 DR. STAMPFER: One possibility is if we go along
12 with kind of major and minor guidelines, then we could have
13 a different format and maybe just have it, you know, limit
14 your intake of salt or something like that.

15 DR. KUMANYIKA: Yeah, that raises different issues
16 though, and I mention later on sort of where to put the
17 importance. But if you start saying "limit," we're back to
18 the avoid and limit type of guidelines. And if I remember
19 correctly from the earliest focus groups, the word "avoid"
20 is not one that's understood by people with limited literacy
21 skills. So. I think it's Dok and Dok who do this
22 presentation.

23 They said when they tested that in focus groups
24 what people actually saw was "sodium" because they didn't
25 understand the "avoid," so they totally missed the message,
26 you know, associated with limiting it, so leave that to the
27 experts in terms of how to convey, you know, if you could
28 get away with that, but we might consider whether "diet" is
29 the right word.

1 DR. DWYER: Shirika, can I ask you one thing on
2 that though?

3 It seems to me there are others who are far better
4 qualified at least than I to do this sort of communication
5 stuff, but on the scientific issue, are we of one mind that
6 the sodium is the problem rather than the sodium chloride?
7 We talked a little about that, didn't we?

8 DR. KUMANYIKA: Yeah. I mean, the chloride
9 evidence has never gotten to the point where it becomes the
10 issue partly because most of the sodium in foods is
11 associated with sodium chloride, so it becomes a moot issue.

12 We did have a presentation last year on the form
13 of potassium that's in foods as an issue related to the
14 potassium data, but I don't know that anybody has thought
15 about whether the other forms of sodium in food are
16 contributing enough quantitatively to be targeted, so I
17 don't think they are considered to be less harmful than
18 sodium chloride. It's just that they're not there in larger
19 quantities.

20 Alice?

21 DR. LICHTENSTEIN: Also from a consumer
22 perspective when you think about discretionary sodium that
23 could be added, it's really sodium chloride, whether it be
24 in cooking or at the table.

25 CHAIRMAN GARZA: I'd like to try to make sure that
26 we don't deal so much with trying to word-smith this at this
27 point because we need -- we need to go ahead and have the
28 document, the full documents in front of us.

29 DR. KUMANYIKA: Okay.

1 CHAIRMAN GARZA: Because if we try to deal with it
2 at this level of specificity, some of you will miss your
3 planes.

4 DR. KUMANYIKA: Yeah. Well, let's --

5 CHAIRMAN GARZA: And I don't think it's doable
6 anyway.

7 DR. KUMANYIKA: -- for these as conceptual issues
8 about how to describe what we're trying to accomplish and
9 leave it to the consumer research to help us decide that in
10 the final analysis.

11 Okay, the key points in the guideline that are
12 there now are that it's appropriate at this juncture just to
13 get some kind of confirmation that these are things that
14 should be continue to be addressed or added to the text:
15 the definition -- yeah, just to make sure people know what
16 it is we're talking about. Intake is too high. It's higher
17 than physiological needs. Do we want to add something about
18 that eating out may increase sodium intake, which has
19 appeared other places, but most recently in this USDA
20 analysis? That it's mainly in processed and prepared foods,
21 which is there now. Can be lowered safety and "role of
22 iodized salt" would be new points to be added, so maybe we
23 could discuss whether there is support for adding -- that
24 "intake may be increasing associated with eating out, that
25 it can be lowered safely," which we really don't cover in
26 the current text, and the "role of iodized salt."

27 CHAIRMAN GARZA: Any comments or questions?
28 Roland.

29 DR. WEINSIER: Yeah. Was there another section

1 you were going to go to?

2 DR. KUMANYIKA: Um-hmm. Well, I just wanted,
3 because some of these will require us to summarize evidence
4 that we've collected, and I think the committee can do that
5 if we think that these topics belong, at least in the next
6 draft.

7 DR. WEINSIER: Yeah. I didn't know if you were
8 going to get to our not, I was just going to come back to
9 the issue that some of these made me a little uncomfortable,
10 not what you said, but in the past guideline that the effect
11 of sodium is basically related to one disease; that's
12 hypertension.

13 DR. KUMANYIKA: Um-hmm.

14 DR. WEINSIER: Whereas hidden somewhere under
15 hypertension is the effect of sodium on calcium.

16 DR. KUMANYIKA: I have that on the next one.

17 DR. WEINSIER: Okay, that's what I was --

18 DR. KUMANYIKA: Any other? Um-hmm?

19 DR. DWYER: I think that something does need to be
20 said about iodized salt, well iodide, that some people are
21 getting too much and some are getting too little.

22 DR. KUMANYIKA: So if it's worth the committee --
23 subcommittee doing the work to try to draft some supporting
24 evidence on those points, we can seek and always come out
25 later.

26 DR. DECKELBAUM: What do you plan to address
27 relative to iodized sat? Is it what Johanna is saying? You
28 know, what moderate intake might do or low intake to iodine
29 sufficiency or?

1 DR. DWYER: I think, at the risk of being --
2 making a mistake, the issue is there are clearly some people
3 who are not getting enough. There are also some people
4 probably suffer from iodide toxicity. It happens to be the
5 only connection with salt is that the vehicle for
6 fortification with iodine in the United States is salt. So
7 it comes in under there, but it's basically something that
8 comes in in the part that we talked about very early this
9 morning that Dr. Lichtenstein presented on the whole issue
10 of fortified foods.

11 DR. DECKELBAUM: I just want to mention one point
12 on that. When you deliberate in iodized salt, because this
13 report is read outside the United States, that iodized salt
14 has been a major step towards eliminating iodide deficiency.
15 In fact, it's a major step worldwide and it's still -- so
16 one has to be very careful, I would say, specifically on
17 this point on how it could be interpreted outside the United
18 States in areas where iodide sufficiency is common.

19 DR. DWYER: Richard, I don't think the point we
20 were making the subcommittee was that we were talking about
21 eliminating that vehicle for fortification. That wasn't --

22 DR. DECKELBAUM: I'm just saying that --

23 CHAIRMAN GARZA: Let me ask if we can let Shirika
24 go ahead and complete her presentation and then we will go
25 to questions. Otherwise, it may take --

26 DR. KUMANYIKA: Yeah, okay.

27 CHAIRMAN GARZA: -- too long.

28 DR. KUMANYIKA: But I think we agree that we need
29 to consider what to say because people are aware that this

1 is a fortification vehicle and if we don't say anything,
2 they don't know how to think about it, and what to say about
3 it is the more complicated.

4 In the guidance -- oh, this is the second over
5 here. We didn't talk about this one yet. And then the next
6 major point is why do sodium intake or salt intake, and
7 there's the blood pressure evidence that can be updated and
8 strengthened based on studies that have come out since 1995,
9 and the other reasons that are or might be listed are shown
10 here: the gastric cancer, asthma, calcium retention. And
11 whether we want to say anything about water intake or water
12 retention here is something I think we should consider.

13 So we have collected references, updated reference
14 on gastric cancer to see if anything is warranted. We've
15 tried for asthma, but literature is very thin. We've fairly
16 good evidence on calcium retention, although the effect size
17 has been questioned by some people, and we might need to
18 translate that into an affect size that's meaningful or
19 otherwise people could get the wrong idea.

20 In the community, water retention is something
21 that people associate with sodium intake and a benefit of
22 reducing their sodium intake is water retention. We never
23 mention water anywhere in the guidelines probably, so we
24 should consider the sodium as a logical place to mention
25 water.

26 In the guidance, we can consider covering whether
27 sodium intake is for everyone. There seems to be a strong
28 sentiment to talk somewhere about salt sensitivity, and we
29 mention that the current guideline it's saying there was no

1 way to tell who is salt sensitive, but we could talk about
2 sodium intake for everyone and maybe pick up some other
3 concerns about adverse effects.

4 Should we try to come up with a practical target
5 range? I think we should try. Whether it will end up in
6 the final booklet, I don't know, but we're going to -- the
7 subcommittee will make some recommendation about whether to
8 include numbers and what they would be, and I'm thinking a
9 range to have a bottom and a top.

10 And then a relationship to overall dietary
11 pattern, possible topics: flavor, convenience and I mention
12 the iodine there, but it might have come up earlier. That's
13 the first part of the relationship to overall dietary
14 pattern, to acknowledge reasons why people might be
15 consuming salt or why it's in foods.

16 And the second part of the relationship to the
17 overall dietary pattern is compatibility with other dietary
18 guidelines and the relative importance in relation of other
19 dietary guidelines if could do that in a way that's
20 constructive.

21 Targeting would be an issue. Are there people who
22 should be particularly interested in sodium reduction; you
23 know, risk of high blood pressure, whatever?

24 So the text in there now about other factors also
25 affect blood pressure will have to come into one of these
26 topics, but it shouldn't necessarily be a main heading.

27 And then finally, how to lower salt or sodium
28 intake or maintain a lower salt intake? There are two
29 categories, and one is discretionary, and flavor issues is

1 where we might talk about substitutions for flavoring; and
2 the other is the obligatory of the salt that's not really in
3 food for flavor, recognizes flavor, but you pick it up as
4 you go along of foods formulated with sodium.

5 The final point that's come up in discussion is
6 whether we should move the potassium box to the fruit and
7 vegetable section. And the more I look at it the harder it
8 is to understand the placement of that big box. As it is
9 now, it really does jump out at you, so fruit and vegetable
10 people, please try to give the potassium box a home in case
11 we want to move it.

12 (Laughter.)

13 DR. DECKELBAUM: Together with nuts.

14 DR. KUMANYIKA: Well, potassium issues, you know,
15 fruits and vegetables are a good sources of potassium.

16 DR. LICHTENSTEIN: I would just like to ask for
17 some data on the magnitude of iodine deficiency and iodine
18 excess in the United States since that's where these
19 guidelines are at least initially intended for, so we have
20 some idea of what the magnitude of the problem, potential
21 problem is.

22 DR. DWYER: The papers in Morbidity and Mortality
23 Reports for -- no, I'm sorry. It's in the Journal of
24 Clinical Investigation. I'll give you the reference.

25 DR. KUMANYIKA: Well, we have a CDC report, but I
26 don't know if the whole committee got it, but certainly we
27 could -- it's the proceedings of the whole conference. It
28 could certainly go to everybody.

29 CHAIRMAN GARZA: Any other questions or comments?

1 Roland?

2 DR. WEINSIER: Yes, just real quick.

3 I think Shirika probably has a better suggestion,
4 I mean, her suggestion is probably better in terms of
5 perhaps moving the potassium to the fruit and vegetable
6 guideline. But did you consider the possibility of maybe
7 letting this one focus on choosing diet low in sodium and
8 high in potassium, and go ahead and address both in this
9 context because many of the disease you're dealing with look
10 at sodium/potassium in inverse relationship, so you could
11 justify doing it. But either approach, you know, should
12 handle the problem.

13 DR. KUMANYIKA: I think that we can consider it.
14 The caution that I've always been aware of is that people
15 are afraid that people will take potassium supplements in
16 other forms, and that there is some people for whom that
17 could be problematic, that they won't take it from the
18 fruits and vegetables. They'll go out and get a potassium
19 supplement and get into trouble. So there has always been a
20 reluctance to recommend potassium increase directly,
21 especially as the evidence doesn't support an independent
22 role in blood pressure. This is very tricky as an advice to
23 consumer issue.

24 Other people have different ideas, but that's
25 where my concern is.

26 CHAIRMAN GARZA: I'm going to allow sort of two or
27 three picky questions now.

28 DR. JOHNSON: Well, I'm just -- the thought
29 crossed my mind that given the results from the DASH diet

1 that this might be a good place also to just continue to
2 pull together the other guidelines, reenforcing fruits and
3 vegetables, low fat dairy products and the food pattern that
4 was useful in DASH, if this is more or less a hypertension
5 guideline.

6 DR. KUMANYIKA: Well, is it?

7 DR. JOHNSON: I don't know. Is it?

8 CHAIRMAN GARZA: All right, Richard.

9 DR. DECKELBAUM: I was just wondering, except for
10 the hypertensive population, which is a significant number
11 of the population, how much of the general population really
12 realize that this is an important -- you know, the
13 importance of potassium, whether that's been covered in any
14 of the focus groups to date.

15 CHAIRMAN GARZA: Probably very little would be my
16 guess.

17 DR. LICHTENSTEIN: Just to reenforce that, I
18 question whether the general population knows what potassium
19 is and whether they would be better served by just putting
20 more emphasis on fruits and vegetables, and that would take
21 care of it.

22 CHAIRMAN GARZA: Scott.

23 DR. GRUNDY: I think that all of this is not
24 exactly a hypertension topic. It certainly is an
25 opportunity to get into hypertension. And if you had a -- I
26 know that it's mentioned in the text about the other factors
27 that affect blood pressure, but a table of those factors
28 might be more valuable than a table of potassium sources, so
29 that you could see in one place a list of all the factors

1 that contribute to hypertension, and that could get into
2 your DASH diet and exercise and other things like that.

3 DR. DECKELBAUM: Factors contributing to a healthy
4 blood pressure or something like that.

5 DR. KUMANYIKA: Yeah.

6 DR. JOHNSON: Yeah, that's good. Can't wait.

7 DR. WEINSIER: But don't leave out the
8 osteoporosis here. I mean, it's the same sort of inverse
9 relationship between sodium and potassium, I think. I would
10 build on that. I mean, this has potential, you know,
11 powerful effects on two major diseases and perhaps others.

12 CHAIRMAN GARZA: The other point that Shirika
13 reminded me of in the presentation, and this applies to many
14 of the guidelines, and I mention it only so that we all can
15 keep it in mind to Carol in the specific prose is the new
16 data that up to 40 percent or perhaps even more of the total
17 food that is consumed is consumed outside the home, and so
18 that in providing guidance for implementation, it's helping
19 people understand how to implement the guidelines,
20 recognizing that close to half the time they are not eating
21 within the household, and that relates to weight maintenance
22 and to fat control and to a number of other issues.

23 And we recognized it in the previous guidelines,
24 but perhaps not as explicitly as we should in this one.

25 So with that, let's turn on then to carbohydrates.

26 DR. JOHNSON: Okay. You'll see where I had Power
27 Point because I am left-handed and don't do overheads
28 particularly well, but I'm sure you will see them.

29 Okay, I'm just going to present a proposed outline

1 for the sugar guideline, followed by proposed changes with
2 some rationale and then further information that we feel we
3 need for this sugar outline.

4 This is just a proposed outline more or less for
5 the technical report, and then we'll pull out for the
6 consumer booklet. I think we probably want to define sugar
7 and I think we need to think about whether or not we want to
8 use or bring in that USDA definition of added sugar, which
9 is sugar that's not naturally occurring in the food product.
10 And it's been very clearly defined by USDA, primarily for
11 use in analyzing their nationwide food consumption data, but
12 we do have that definition.

13 We have put in some information about current
14 added sugar intake in the U.S. by age, various age and
15 gender groups; the primary sources of added sugar, which I
16 covered yesterday. The number one source is carbonated
17 beverages, followed by sweetened grain products and various
18 others, but I believe there were four sources that are the
19 primary sources of about 75 percent of all added sugars.
20 Then some information on the effect of added sugar on diet
21 quality or this nutrient displacement effect that we've been
22 able to demonstrate with our new ability to look at added
23 sugar in large group consumption databases.

24 Some information on the changing beverage patterns
25 in the U.S. and their effect on -- particularly on calcium
26 intakes. I think we need to think about how much we want
27 top up in there about sugar and disease patterns. I think
28 the data are fairly weak on sugar and weight diabetes and
29 cancer, although that world cancer book did recommend

1 reducing sugar, particularly sucrose, for reduced cancer
2 risk, although Dr. Byers yesterday in his presentation did
3 emphasize that he felt the data were weak there.

4 I'd like to see us reenforce what was in the '95
5 booklet, that sugar does not appear to be related to
6 children's behavior pattern and continue to try and put to
7 rest the myth that sugar causes hyperactivity or other types
8 of deviate behaviors in children, and some information on
9 dental carries sugar and carry genecity.

10 In the '95 booklet, there is information on
11 artificial sweeteners. It's fairly brief. I'd like some
12 feedback on whether or not you'd like to continue artificial
13 sweeteners and mention of them. I found one study that
14 related use of artificial sweeteners to enhancing long-term
15 weight maintenance, but I think, again, the data are sparse
16 in that area.

17 Some of the things the subcommittee has talked
18 about on proposed changes, and I'm not saying, you know,
19 this is the final wording. It's just trying to put the
20 thoughts together that everyone had, that we'd say something
21 like "Choose a diet moderate in food and beverages with
22 added sugars," and these changes were proposed primarily
23 with the intent being to try and emphasize those foods and
24 beverages high in added sugars with low nutrient density,
25 and I heard several times over and over to give special
26 emphasis on beverages since clearly they are the primary
27 source of added sugars in the -- in American's diets.

28 One big problem that was very clearly brought to
29 my attention yesterday by Kathryn, which I really

1 appreciated, is that the food labels don't currently
2 distinguish added sugars. And if you look in your dietary
3 guideline booklet on page 13 and 13, you'll see a sample
4 food label. And what Kathryn showed me yesterday, she put a
5 can of 100 percent orange juice next to a can of carbonated
6 beverage, and the total sugar content was very similar. So
7 if a consumer looks at the food label and looks at sugar,
8 it's not distinguished, and you'd really have to go into the
9 ingredients to try and distinguish those added sugars. So I
10 think that could be problematic if a consumer is trying to
11 identify added sugars, although I think we could provide a
12 lot of information about that in the booklet.

13 Some of the information that I think we still need
14 are the consumer information that we've been talking about
15 getting, the understanding of the term "added sugars" versus
16 just "sugars." I'm not really convinced that when we say
17 "sugars" to consumers, do they think of fructose in fruit.
18 According to Dr. Geiger's report, there is some confusion on
19 the part of consumers when we tell them to eat a lot of
20 fruits and then we tell them to moderate their sugar intake,
21 but I'm not really clear how we could best deal with that in
22 a guideline.

23 Do consumers understand that things like corn
24 syrup and high fructose corn syrup, which are used as
25 sweeteners, would be included in that category of added
26 sugars? And yesterday one of the committee members asked
27 for some strengthening of the information in the data that
28 we have on the carcinogenicity of various sugars.

29 Okay, that's --

1 CHAIRMAN GARZA: Any questions or comments from
2 either other members of that working group or the whole
3 committee if none of the working group wants to add?

4 Meir.

5 DR. STAMPFER: Just real quick.

6 I think we should be cautious about the sugar
7 substitutes. I think the current booklet has it right.
8 Unless you reduce total calories, use of sugar substitutes
9 will not cause you to lose weight, and I wouldn't put much
10 emphasis on that new study because it was part of a whole
11 program of weight loss. It wasn't just specifically testing
12 sugar substitutes.

13 In the Nurses' Health Study, who have gained more
14 than a million pounds, the number one dietary predictor of
15 weight gain was saccharin.

16 CHAIRMAN GARZA: Well, that may be a totality, but
17 this does raise the point that Scott has made often; that
18 we may want to strengthen our attention of strategy that
19 people might use to limit their total intake, and so the
20 addition of a sugar substitute may give people license to
21 then have twice as much of something else and not understand
22 that it is a caloric balance issue, so maybe we could move
23 some of that to the weight gain to deal with that issue.

24 DR. DWYER: Just two points, the first is the
25 last.

26 In addition to what you mentioned, Rachel, it's
27 also important to consider the carcinogenicity of various
28 fermentable carbohydrates. The point is that it is not
29 limited to sugars; it is also other carbohydrates that are

1 fermentable, so it's a mistake to just link it one way.
2 You'll get a negative when it might be positive.

3 The other is, it seems to me that it's sensible
4 biologically to consider -- also presenting, presenting
5 total intakes of carbohydrates and then various breakouts
6 under there in the first part where you're talking about
7 defining sugars, and I think that way --

8 DR. JOHNSON: I don't understand that. Can you
9 clarify?

10 DR. DWYER: What I mean is you said on your
11 outline first was the definition.

12 DR. JOHNSON: Um-hmm.

13 DR. DWYER: And then current use of added sugars.
14 What I am saying is it would make more sense to me to do
15 total, total carbohydrate and total whatever it is, sugars,
16 and then within that do the added, so you get a whole idea
17 of that category.

18 Does that make sense?

19 DR. JOHNSON: Yes, I see what you're saying.

20 DR. DWYER: Because that will link it back to
21 where the label is now.

22 CHAIRMAN GARZA: Okay, any other -- Scott.

23 DR. GRUNDY: The way this is -- the way you have
24 written on page 33 of this about the link of sugar to
25 overweight, it's very ambiguous and I think that it does
26 contribute to overweight, and that has to be made clear.
27 Every calorie you take in excess contributes, and this is
28 one way to help to limit calories, so there is multiple
29 reasons for limiting sugar, but I don't think it's written

1 in a very good way here.

2 DR. JOHNSON: If you have any citations that link
3 sugar intake with weight, I would very much appreciate them
4 because I know what you're saying about total calories, but
5 the data is very sparse when you compare people with high
6 sugar intakes to people with lower sugar intakes, and look
7 at weight as an outcome. The data is sparse.

8 DR. GRUNDY: I think here is my -- I'll tell you
9 the problem, I think, is that you can't relate any one
10 single thing in studies to the overall weight of a
11 population. It's the total caloric intake from multiple
12 sources, so people that would look at fat, and you can't
13 find a relation to fat to weight, you can't find a relation
14 to sugar to weight or any particular thing. But there is no
15 question that the sum of all of those is what makes the
16 total caloric intake, so the studies can't be done in that
17 way.

18 DR. JOHNSON: Well, you can't even relate total
19 energy intake to weight because of the problem of
20 underreporting, so we can't even prove that total energy is
21 related to weight very effectively.

22 CHAIRMAN GARZA: But we do know something about
23 physics.

24 DR. GRUNDY: Yeah, that's right. We are fortunate
25 in that regard is we do know certain things about physics
26 and chemistry. We know your students --

27 CHAIRMAN GARZA: I said "some," not all.

28 (Laughter.)

29 CHAIRMAN GARZA: Shirika.

1 DR. KUMANYIKA: In looking for data, there may be
2 data relating behaviors, like intake of certain type of
3 foods rather than the total calorie intake, and I'm thinking
4 of just one study. So if you ask about food patterns, you
5 may be able to pick something up which is suggestive without
6 knowing the mechanism that these behaviors are associated
7 with weight.

8 DR. KUMANYIKA: Right. We do have the data that
9 say that -- that associate particular foods with increased
10 energy intake over the last five-year period, so that could
11 be helpful because there is some data that soda is a large
12 part of that component of the increased energy intake.

13 CHAIRMAN GARZA: Okay. The only other thing that
14 I would add in terms of your data needs is to look more
15 explicitly at other age and physiological groups in relation
16 to the whole displacement issue. I'm thinking not only of
17 the elderly, but of pregnant women, lactating women, in
18 addition to adolescents. If there are specific groups that
19 we need to be concerned about, we need to identify them and
20 see whether there are any data that would help support.

21 DR. KUMANYIKA: Right. As I said, we did that
22 analyses controlling on age and gender, but Shanthy and I, I
23 think, can break it down to see --

24 CHAIRMAN GARZA: Yeah, so I think it's an easy
25 thing to do.

26 DR. KUMANYIKA: -- and we can do that.

27 CHAIRMAN GARZA: All right. Okay, then --

28 DR. LICHTENSTEIN: One last thing.

29 I think we talked a little bit yesterday, Rachel,

1 about the diseases. Like you were saying obesity, in your
2 view, doesn't link to added sugars, but some others do.
3 Maybe it would be helpful if we could just consider a grid
4 next time that starts with total calories and goes all the
5 way down to this added sugars category, but that also
6 includes carbohydrate fermentable, non-fermentable, total
7 sugars and then added sugars, so we can see how those things
8 work out. They are not all the same. Some of the issues
9 are only affected by one of those and some perhaps by
10 others, like total calories. Certainly everybody would
11 agree is associated --

12 DR. KUMANYIKA: I see what you're saying. A gird
13 of disease and then the effects of carbohydrates --

14 DR. LICHTENSTEIN: Correct, yeah.

15 DR. JOHNSON: Just for our own use really to think
16 about --

17 DR. LICHTENSTEIN: Yes, for our own usee.

18 CHAIRMAN GARZA: Okay, we will be moving on to
19 alcohol.

20 DR. STAMPFER: This is the same overhead I showed
21 yesterday, and this was supposed to be a controversial
22 guideline but actually there doesn't seem to ge a lot of
23 sentiment for major changes in this guideline, and I think
24 most of the changes are in the category of word-smithing,
25 which I don't want to go into now, and we can do that as we
26 refine the document.

27 Just to briefly mention some of the word-smithy
28 type things, without getting into the words themselves: a
29 greater emphasis on adverse effects coming up front. I

1 think that was a good suggestion; clarification on alcohol
2 use in pregnancy and medications.

3 This is a nonword-smith issue which we could
4 discuss is whether we should specifically target different
5 age groups because the risk and benefits vary by age and
6 also gender. Should we specifically target or mention
7 breast cancer risk? Right now it says "certain cancers."
8 It's vague. My own view is that we should.

9 There is one word-smithy thing which I would like
10 to get some feedback on, which is this sentence that several
11 people have mentioned. It's the third sentence in the
12 booklet. "Acoholic beverages have been used to enhance the
13 enjoyment of meals by many societies throughout human
14 history." And I'd like some guidance here because our
15 charge was to only make changes where there is very clear,
16 good scientific evidence that the guideline is wrong or
17 somehow faulty. And this sentence is obviously true, and I
18 don't think anybody can come up with scientific evidence to
19 the contrary. So if we want to change this sentence, then
20 we need to apply some other principle, and I don't know what
21 the sentiment of the committee is for doing that.

22 The reason that sentence was put in, as I
23 mentioned earlier, was to emphasize alcohol as part of the
24 diet as opposed to alcohol as a drug. And to that end, I
25 think that the intent was correct, to promote moderation and
26 alcohol is part of the diet, but it's an issue that maybe we
27 ought to have a few words about.

28 So that's all I had to say about alcohol.

29 DR. LICHTENSTEIN: I have a problem with that

1 sentence because I think it's inconsistent with the way the
2 other guidelines and other types of foods and components of
3 foods are presented.

4 CHAIRMAN GARZA: Roland.

5 DR. DECKELBAUM: I support that. This is
6 encompassed on page 1 of the introductory section where
7 "Food choices depend on history, culture and environment, as
8 well as on energy and nutrient needs. People also eat foods
9 for enjoyment." I think it's encompassed in the general
10 guidelines. I think it's out of place, specifically.

11 CHAIRMAN GARZA: And, unfortunately, it's being
12 misconstrued. I mean, that, I think, is the other
13 principle; that as an endorsement or a recommendation or an
14 encouragement people should adopt drinking for pleasurable
15 reasons and that, I think, we also take into account.

16 DR. DWYER: I think the problem is that it isn't
17 false. The issue is singling out any one thing and saying
18 something special about that. For instance, if we instead
19 of nuts, Meir, if you consider avocados, for example, if you
20 start singling out any one specific thing and saying it is
21 good, I'm not sure that's our purpose here. And so I guess
22 we'd have to say that maybe it should be taken out.

23 CHAIRMAN GARZA: I don't know who it was, but
24 somebody commented, I found it convincing that to be
25 consistent we'd have to say, well, you know, fat adds to
26 enjoyment and salt adds to the enjoyment and sugar, and so
27 the -- I mean, yeah, we've singled that one out, and if it's
28 encompassed in the introduction, then perhaps that's
29 sufficient, but I would take that principle. But once we

1 adopt that, to be careful that in fact we're being
2 consistent in other ways throughout the guidelines as well,
3 so I don't want to single this inconsistency alone. I think
4 we need to look for others and make sure that we're not
5 doing this in relationship to other of the guidelines.

6 Is that helpful?

7 DR. STAMPFER: Yeah. Yeah, I think that's very
8 helpful, and also if people have other ideas about a message
9 that would enforce the moderation and dietary aspect without
10 being in the same tone as this sentence that a lot of people
11 seem not to like, then, you know, that would be good to work
12 into the wording.

13 CHAIRMAN GARZA: Okay. Any other comments related
14 to the alcohol guideline?

15 DR. STAMPFER: Can I get a sense of the sentiment
16 of the group on whether to specifically mention breast
17 cancer and also whether to specifically mention age groups
18 and the difference in the risk and benefits?

19 CHAIRMAN GARZA: Richard.

20 DR. DECKELBAUM: I'd agree just to reenforce -- I
21 don't think you need a replacement sentence of that sentence
22 were used --

23 DR. STAMPFER: Oh, no.

24 DR. DECKELBAUM: -- you know, you go on right to
25 the next paragraph about, you know, the benefits of, you
26 know, moderate intake, and leaving that sentence in actually
27 is something that's -- you know, women are only allowed or
28 should only have half the amount of a man does in terms of
29 this accompanying enjoyment with meals. It's

1 discriminatory.

2 (Laughter.)

3 CHAIRMAN GARZA: No, I do think that to the
4 degree, Meir, that the group can give the American public
5 the very best guidance in terms of what the risks are as
6 well as what some of the punitive benefits of moderate
7 drinking may be so that in fact people can make their own
8 choices will be important, but it's giving the public .the
9 beset information we can of both sides of that coin. And as
10 we heard from Dr. Gordis and your presentation and the
11 presentation from Tim Byers, it's not a simple story, and
12 it's not going to be an easy statement to craft because of
13 that, but I think we need to be inclusive of the data, of
14 all the data, both risk and benefits in as objective a
15 manner as we possibly can.

16 DR. WEINSIER: For consumer purposes, we use the
17 word "moderate" and "moderation" frequently in here and
18 specifically with regard to three guidelines, and I'd just
19 like to be ceratin that that is interpreted appropriately as
20 we intended by the consumer.

21 CHAIRMAN GARZA: I'm sure Carol has added that to
22 her list.

23 DR. JOHNSON: I'd just like to answer your
24 question about breast cancer, and I say yes, I think we need
25 to say something about the risk, because now it just says
26 "some cancers" or "certain cancers," and I think from a
27 female perspective we really would like to point that out
28 because it's a major concern to a lot of women.

29 CHAIRMAN GARZA: No, that's fine. I think

1 wherever we can be more specific. I think it's going to be
2 difficult in adhering to our guidance of trying to keep it
3 concise and yet give people the holistic picture with
4 specificity.

5 All right, I've talked to the two heads of the two
6 working groups that we still have to listen in terms of
7 whether we should break for lunch before or after, and they
8 have both assured me they will need about five minutes, so
9 we're going to do the next two, break for lunch, and then
10 come back and adjourn. And so we should be done, I hope, by
11 about 1:30.

12 DR. LICHTENSTEIN: Okay, there were no further
13 formal deliberations on the -- or informal deliberations on
14 the issue of supplements. Right now most of the information
15 on supplements is in the first guideline, whatever that
16 first guidelines ends up being. I haven't heard any
17 suggestions that it should actually be moved to another
18 guideline.

19 There was a little bit about it on grains, fruits
20 and vegetables, but we'll just have to reassess what's going
21 on there.

22 One option is no further change, but that's
23 probably not a good idea because at the very least we need
24 to update the text consistent with what the new changes have
25 been with respect to foliate and as Dr. Dwyer has just
26 pointed out, iodine and salt just never got in there to
27 begin with.

28 I think we also have to do a better job, or it
29 seems to be the consensus that we need to do a better job as

1 far as distinguishing between trans that are added due to
2 government policy versus those that are discretionary, and
3 perhaps include a glossary or some definition of what the
4 current terminology is, especially with respect to what the
5 consumer sees and hears as far as enriched, fortified, or
6 other kinds of things.

7 In addition, between the 1995 and the current
8 guidelines now, there are health claims as far as structure,
9 function claims, and I think we need to give some guidance,
10 and that's missing with respect to what's currently in the
11 guideline.

12 There also maybe need to put some text in
13 regarding what health claims are, what they mean, how do I
14 use them, how do I react to them, acknowledging that these
15 things or these claims now are on food labels and food
16 packages, and we do have a text now entitled "Where do
17 vitamin, mineral and fiber supplements fit in," and perhaps
18 that needs some modification, again, consistent with what
19 current definitions are and current usage.

20 One potential is to actually take this whole
21 supplement and the supplement subcommittee and actually
22 merge it with the previously called variety subcommittee.
23 And least this be interpreted as a hostile takeover, I
24 assure you it's not.

25 (Laughter.)

26 I happily concede my chairmanship, and perhaps can
27 pick up fruits and vegetables or something, but I think's --
28 right now I think that would be the most efficient and
29 appropriate way of handling this whole topic after having

1 explored other options.

2 CHAIRMAN GARZA: Any questions or comments?

3 Shirika.

4 DR. KUMANYIKA: I'm listening to this based on my
5 experience of being on the Commission on Dietary Supplement
6 Labels, and thinking that so far your subcommittee is
7 enjoying the luxury of thinking only about certain types of
8 supplements. So I would suggest that what is a dietary
9 supplement that helps a consumer understand there are many
10 types of things called dietary supplements, and that this
11 guidance has to do with the ones that have -- you know,
12 there are vitamins and minerals, or whatever we decide, but
13 that we really help the consumer to figure that out in
14 addition to structure, function, claims and health claims.
15 It's going to be hard to craft something short, but we
16 should integrate the deche and dietary supplements fully
17 into the dietary guidelines, I think, and I'll volunteer to
18 add myself to your subcommittee, which I think should remain
19 separate for that purpose.

20 DR. LICHTENSTEIN: I'll let the Chair handle that
21 one.

22 CHAIRMAN GARZA: The only other point that we
23 should probably think about, and that's this whole working
24 group, including Shirika, is the difficulties that the
25 working group faced in terms of the database, trying to
26 determine the role of supplements in the American diet
27 because often the consumption surveys and both done by DHHS
28 and USDA are very -- present us with difficulty in trying to
29 answer or understand the role that supplements are presently

1 playing in the American diet.

2 And if we're going to craft any information, at
3 least in the future, that is very informed, then making some
4 recommendations as to how that data collection could be done
5 may be useful.

6 Is that a fair statement, Suzanne?

7 DR. MURPHY: Sure. I mean, the more data you have
8 to make informed decision the better off.

9 CHAIRMAN GARZA: Is the data as poor as I perceive
10 it to be or is it -- could we have other analysis that we
11 haven't done to date that could inform what we're doing?

12 DR. MURPHY: Well, to my knowledge, the only
13 released -- there are not any released information from
14 NHANES III on the contribution of supplements to diets, but
15 I believe that's fairly imminent, and I don't know if anyone
16 wants to make a statement to that effect, but that
17 information would indeed be useful for us, and I think,
18 hopefully we'll have it before we finalize the guidelines.

19 But as an ongoing request from this committee and
20 many others, it's very helpful when the national survey data
21 give us information on supplement use.

22 CHAIRMAN GARZA: Okay. Well, maybe we could sit
23 down with Shanthy and see what we can do through
24 interdepartmental cooperation, getting some of that
25 information.

26 Scott.

27 DR. GRUNDY: Just one point.

28 In expanding this area a little bit, the public is
29 increasingly bombarded with new types of foods out there and

1 also food additives like fat substitutes added to food,
2 which the FDA called food additives, and now we're going to
3 see more and more enriched foods like catsup enriched, all
4 kinds of things. And, you know, having some interest in
5 what the industry is doing, we're going to see a tremendous
6 amount of this.

7 Now, we can't cover these points, but I think in
8 this definition of the different categories of supplements,
9 food additives, enriched foods, it would be helpful to the
10 public to have all that in one place. I think Shirika
11 alluded to that, but we haven't talked about food additives.
12 That came up once previously in our discussion talking about
13 fat substitutes, where do they fit in and so forth, so I
14 don't know.

15 CHAIRMAN GARZA: No, I was laughing because --

16 DR. GRUNDY: At least a table.

17 CHAIRMAN GARZA: -- we may have solved your potato
18 problems.

19 DR. GRUNDY: Yeah.

20 CHAIRMAN GARZA: We have like a peanut enriched
21 catsup.

22 VOICE: Put on our french fries.

23 CHAIRMAN GARZA: French fries, that's funny.
24 Johanna.

25 DR. JOHNSON: Does it count as a vegetable in the
26 school lunch program?

27 CHAIRMAN GARZA: Why not?

28 Johanna?

29 DR. LICHTENSTEIN: I think the combined survey

1 that USDA and HHS are now deliberating, getting started,
2 might have better information than prior surveys, and so
3 perhaps it would be a useful statement to include, that this
4 is important.

5 CHAIRMAN GARZA: All right, then, if we're ready,
6 we'll move on to food safety.

7 DR. DWYER: I will try to make this very quick.

8 We talked about it last so people were tired and I
9 suppose because of that they agreed. There was one thing
10 that has come up between now -- between yesterday and today
11 that needs attention, and that is that we need to get, in
12 terms of the data, the scientific evidence, we need better
13 data on deaths.

14 Yesterday we received -- those of us on the
15 committee received a little bulletin. Since then I
16 inquired. The NCHS -- I think it was the NCHS model that
17 the use for estimating deaths from foodborne illness
18 probably was not a very good, or the extrapolation that they
19 made from illnesses to deaths was probably not appropriate,
20 so we need help from CDC or FSIS or somebody to do a better
21 estimate there in the rationale.

22 We deliberated briefly on the various
23 possibilities for something to say and came up with the
24 "Handle food safety from market to table," one, is probably
25 the most actionable for consumers. We haven't discussed
26 very much the issue of exactly what shall go in it, and let
27 me just mention a few things that might be the core of a
28 separate guideline on food safety.

29 First, the greatest degree of consensus among the

1 experts consulted was on bacterial foodborne disease because
2 it's the most common problem and easiest for consumers to
3 prevent by their actions.

4 Next slide.

5 It's not that there aren't other issues. It's
6 that these are issues that the experts all agree are there.
7 These guidelines that Dr. Woteki talked about -- the ones
8 about clean, separate, cook, chill, follow the label, serve
9 safely, if in doubt, throw it out -- seemed, again, to be
10 well justified, things that people can do that really do
11 help.

12 Next slide, please.

13 Also, there seemed to be a good deal of consensus
14 about who the groups are who need special help: pregnant
15 women, very young children, older adults, and then people
16 who are immunosuppressed for a variety of reasons.

17 Next slide, please.

18 This, in the questions that Dr. Suitor posed, came
19 under some scrutiny because it's very long and the question
20 is: Do you really need something that says temperature? Do
21 you need a chart if you make text? And I would suggest that
22 if it's used at all, it should be something that's a better
23 graphic than this, but not text; just throw in an
24 illustration.

25 Next slide, please.

26 I think that's it. Basically suggest that this be
27 a separate guideline because it fits better, I think, by
28 itself than it would under nutrients or something, some
29 other rubric.

1 CHAIRMAN GARZA: Any questions or comments?

2 Either the troops are hungry or it was right on
3 target, and I hope it was the latter.

4 All right, then, we will adjourn. We will be back
5 at 1:15 and we'll wrap up in 15 to 20 minutes, and we should
6 be out of here by 1:30.

7 (Whereupon, at 12:30 p.m., the hearing was
8 recessed, to reconvene at 1:15 p.m. this same day,
9 Wednesday, March 10, 1999.)

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1 A F T E R N O O N S E S S I O N

2 (1:21 p.m.)

3 CHAIRMAN GARZA: Okay, we are reconvening. I want
4 to thank the group for taking such an efficient lunch and
5 being back on time.

6 The first order is to make sure that everybody has
7 the meeting that's scheduled for June on your calendars, and
8 we have the final dates on that, and we are aware that there
9 is one of us with a conflict on the last day, and so I
10 apologize, because we couldn't find a date that was suitable
11 for everyone. And then we've got some dates -- tentative
12 dates for September.

13 DR. STAMPFER: What is the date?

14 DR. BOWMAN: The June date, it's a Wednesday,
15 Thursday and Friday, that's all I know.

16 DR. SALTOS: Sixteenth to the 18th, I think.

17 DR. BOWMAN: Sixteen, 17 and 18.

18 DR. SALTOS: You're telling me the June one?

19 DR. BOWMAN: That's correct.

20 CHAIRMAN GARZA: And for September, we had
21 originally planned what?

22 DR. BOWMAN: September was 7th, 8th and 9th,
23 something like that.

24 CHAIRMAN GARZA: Yes, that's right. I've got them
25 right here. Seventh, 8th and 9th, and what we've been asked
26 is to see if we can possibly do it the preceding week.

27 DR. BOWMAN: No, the week following.

28 CHAIRMAN GARZA: The week following.

29 DR. BOWMAN: Because for these three dates this

1 auditorium is not available. We will have to do it at a
2 different place and then we won't have all this service.

3 CHAIRMAN GARZA: And I'm tied up the week of the
4 13th, but the week of the 20th -- you can't come the week of
5 the 20th?

6 DR. BOWMAN: I think we can have the meeting in
7 the Jefferson Auditorium.

8 DR. GRUNDY: Since most of us are locked into
9 that, why don't we just have it at another place?

10 CHAIRMAN GARZA: Yes, I think that may be the --

11 DR. DWYER: What is the date?

12 CHAIRMAN GARZA: The date is the 7th, 8th and 9th.

13 DR. DWYER: That's not Labor Day, is it?

14 CHAIRMAN GARZA: No, Labor Day is on the 6th.

15 Would the 8th, 9th and 10th work better? That's
16 a Wednesday, Thursday and Friday, as opposed to Tuesday,
17 Wednesday and Thursday.

18 DR. DECKELBAUM: That's just right at the
19 beginning of our term, so those of us who have student
20 bodies that we have to handle, like provosts and things --

21 CHAIRMAN GARZA: Well, for us it actually works
22 out well because we start before Labor Day, but I recognize
23 that's just Cornell schedule, that's not your schedule.

24 DR. DWYER: I agree that it can't be the following
25 week, but what about the week after that?

26 CHAIRMAN GARZA: Well, the problem is that the
27 week of the 20th, there are a number of people who can't do
28 it. The week of the 13th, there are a number of people that
29 can't, so we're locked into either the preceding week -- I

1 don't know whether we explored that.

2 DR. JOHNSON: I can't. I can't.

3 CHAIRMAN GARZA: All right, so that's the week.

4 So it's the 8th, 9th and 10th, though.

5 Shirika?

6 DR. KUMANYIKA: Do we need a three-day meeting or
7 do we know --

8 CHAIRMAN GARZA: Well, my preference is for us --
9 to ask you to hold the three days,, and then in June, if
10 it's clear that we're going to have a fairly efficient
11 meeting in September, then we might be able to reduce it to
12 one and a half days, but we'll have a better sense.
13 Liberating a day and a half for you will be much easier than
14 asking you to find a day and a half that late into the
15 season.

16 All right, so people have those dates?

17 DR. DECKELBAUM: The 8th, 9th and 10th?

18 CHAIRMAN GARZA: That's right. Wednesday,
19 Thursday and Friday.

20 Now, I have to say that that Rosh Hahanah starts
21 on the 10th at sundown.

22 DR. LICHTENSTEIN: You know, we ran into that at
23 the last meeting.

24 CHAIRMAN GARZA: But if we end at 12, would that
25 be suitable or would that present real problems? Well,
26 then can we go back to 7th, 8th, and 9th? I wanted to make
27 sure that people were aware of that.

28 DR. KUMANYIKA: That's why I mentioned the two
29 days because I saw Rosh Hahanah on my calendar and I

1 thought, well, some people will not want to --

2 CHAIRMAN GARZA: So we'll go back to the 7th, 8th
3 and 9th?

4 And then in June, we've got the 16th, 17th and
5 18th. I'm going to be real optimistic and not plan any for
6 November.

7 Okay, the only other thing is whether there is
8 anything that -- any other business that has -- we've
9 transacted today the changes, any of the plans we made with
10 Carol earlier in terms of everybody understands what we're
11 going to be needing in terms of response times. I think
12 Carol has a pretty good sense of beginning with the
13 information she's been given. We need information that's
14 comparable for the physical activity. We're going to start
15 working on that. Then we've got -- if we're going to split
16 or consider splitting the grains from fruits and vegetables,
17 then the group needs to provide some guidance as to how to
18 best do that from the current guideline, and so Richard will
19 start working on that with his group; the adequacy/variety
20 guideline and introduction supplements, we'll start working
21 together so we can provide some guidance for Carol there,
22 and everything else, I think you've got pretty --

23 DR. SUITOR: Or I'll ask for it.

24 CHAIRMAN GARZA: And we all will respond, right?

25 DR. SUITOR: Promptly.

26 DR. KUMANYIKA: One comment before you leave. Is
27 it possible for the feasibility of standardizing the format
28 across guidelines as you go through them to say the same
29 types of things about each issue in a similar order. I

1 mean, not rigidly, but to give some uniformity and see if
2 that's -- and advise us on whether that's feasible.

3 DR. SUITOR: We'll have to do that anyway.

4 CHAIRMAN GARZA: That's going to be a goal.

5 DR. KUMANYIKA: Okay.

6 DR. DECKELBAUM: Actually, if I could just comment
7 on that.

8 Carol, it might be helpful if -- that might be
9 actually the first thing that you did. If you gave each of
10 the groups a format of how you would like us to give you the
11 material, then it would be easier for you to cut and paste
12 later. So we can prepare our material along the suggested
13 guideline, you know, outline order.

14 DR. SUITOR: I'll e-mail you what I would suggest.

15 CHAIRMAN GARZA: And then what we'll do, as each
16 of the groups feels that they're coming pretty close to a
17 draft they want to discuss with the group in June, then
18 we'll make sure everybody gets that. And as those begin
19 accumulating, it will be clear as to what the format will be
20 because I'm sure it will have evolved to a certain degree.

21 DR. GRUNDY: I have worked very nicely with
22 Kathryn. Is that going to shift now?

23 CHAIRMAN GARZA: No.

24 DR. GRUNDY: We will still --

25 CHAIRMAN GARZA: No, as far as I know, you'll --
26 the working groups will keep the same -- the same contact
27 person, but in terms of actual drafts, then those will be
28 coming from Carol. If you're not responsive, then the
29 individual we will hold accountable for you not being

1 responsive will be the federal presence you've been
2 assigned, so Kathryn may be at your doorstep.

3 MS. MCMURRY: Thank you, thank you for that
4 responsibility. But we will be available to -- you know,
5 everybody has a resource.

6 CHAIRMAN GARZA: That's right.

7 MS. LYON: If anybody has a problem getting
8 publications, whether they are government or non-government,
9 arranging conference calls, and I would suggest that because
10 of your busy schedules that we try to schedule the
11 conference calls early, earlier than later.

12 CHAIRMAN GARZA: That's right. And then Johanna,
13 did you have -- I'm sorry. And I was looking at the wrong
14 person.

15 DR. DWYER: I just wanted to say that I think from
16 all of us that we really thank you for all this detail.
17 It's been stressful. You deserve a lot of things.

18 DR. GRUNDY: I second that.

19 CHAIRMAN GARZA: Well, on that note before we
20 adjourn, and I actually want to thank not only the staff,
21 but each of you. I mean, it's really been a very
22 efficiently working group from conference calling to e-
23 mailing, and it's that sort of commitment and presence that
24 makes this whole process possible. So the staff, believe it
25 or not, has not complained about any of you.

26 (Laughter.)

27 And I generally get lots of complaints in other
28 committees about, gee, you know, somebody is not being
29 responsive. So congratulations. That's not an invitation

1 to slacken off. That's to set the bar so that we expect
2 that you will continue being as cooperative and committed to
3 this whole process.

4 So unless there is any other housekeeping to be
5 done, the meeting is adjourned.

6 (Whereupon, at 1:33 p.m., the meeting was
7 adjourned.)

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Name of Hearing or Event

N/A
Docket No. _____

Washington, DC
Place of Hearing

March 10, 1999
Date of Hearing

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